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Issue Date: 11 March 2003

In the Matter of	:	Case No. 2002-LHC-00219
	:	OWCP No. 6-166878
CASPER KNIGHT	:	
Claimant	:	
v.	:	
ATLANTIC MARINE, INC. & SOMERSET INSURANCE	:	
Employer/Carrier	:	
and	:	
DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS	:	
Party in Interest	:	

Before: Stuart A. Levin
Administrative Law Judge

For Claimant: Robert Johnson, Esq.
Michael J. McHale, Esq.

For Employer: Kathleen K. Charvet, Esq.
Daniel T. Plunkett, Esq.

For Director, OWCP: Phillip Giannikas, Esq.

Decision and Order

This case arises pursuant to a claim for compensation under the Longshore Act filed by Casper Knight of Jacksonville, Florida. On May 8, 1995, Knight was working as a shipfitter aboard the "Kanesville Queen," a ship then under construction, when he fell off a ladder striking his left knee against a bulkhead. CX. B; F; Tr. 194; 199. He experienced pain and swelling in the knee and was initially treated conservatively. CX. F Tr. 194; 199. When his condition failed to improve,

Knight underwent left knee surgery on June 30, 1995. Tr. 194. Following surgery, he worked in sheltered employment from July 14, 1995, to October 9, 1995, when he was terminated. The parties agree that Claimant's average weekly wage is $520.00. CX. B.

Knight alleges that, as a result of the injury or the subsequent surgery, he developed a residual condition known as reflex sympathetic dystrophy (RSD) which effected his entire body and rendered him temporarily and totally disabled until he allegedly reached maximum medical improvement on February 23, 1998. He claims permanent total disability thereafter. Tr. 197; Tr. 203-04. In this proceeding, Knight seeks compensation and other benefits for periods they were suspended from September 20, 2001, to January 4, 2002; and, in addition, he demands various other benefits including, *inter alia*, new or modified living quarters, 32 hours of home attendant care per week, and an in-home jacuzzi spa.

Employer suspended Knight's benefits, it contends, because he failed to cooperate with an IME it wanted him to attend at the Cleveland Clinic, and it denies he needs the other relief which he seeks. In addition, Employer contends that Knight has failed to follow the recommendations of health professionals who have treated him or provided consultant recommendations, and therefore, he has not reached MMI. Tr. 239-40. It argues that it has approved the physicians Knight has selected to provide treatment for his condition, but after six years and nearly a million dollars in medical benefits, (See, Ex 39A; 39B), Knight is worse off now than he was several years ago. His current treatment, it notes, provides only temporary relief and the prognosis of his physicians anticipates no improvement. The Employer argues that the care Knight presently receives is not in his best interest, and, cites a body of medical evidence in the record indicating that Knight needs a multi-disciplinary pain management approach to his care formulated by a team of health professionals who are expert in treating CRPS. It, therefore, seeks an order authorizing changes in the current care and treatment regime Claimant receives. Finally, Employer interposes a defense under Section 8(f) of the Act in the event Knight is found permanently and totally disabled.

Reflex Sympathetic Dystrophy (RSD)

Before turning to the merits of this matter, it may be helpful briefly to describe the disorder which is the focus of this proceeding. RSD is a condition characterized by increased and abnormal, painful activity in the sympathetic or

involuntary nervous system which controls such bodily functions as heart rate, blood flow, size of the pupils, and sweating. Tr. 650; 657. In recent years, the term RSD has been subsumed by a condition called complex regional pain syndrome, (CRPS). Characteristic diagnostic factors for CRPS include: (1) increased sweating; (2) hypersensitivity to light touch or allodenia; (3) osteopenia or bone loss, (4) atrophy; (5) temperature differentials, (6) changes in skin color; and; (7) hair growth pattern changes.

The condition typically develops after some sort of injury but seems unrelated to the severity of the initial injury. The record shows, for example, that RSD or CRPS can develop following incidents as trivial as stubbing a toe or dropping something on a foot, and physicians who treat this condition remain largely mystified by the mechanism which produces RSD or CRPS in some individuals but not others with similar degrees of trauma. Symptoms may be temporary or permanent, may vary in degree from patient to patient, and, in some cases, may migrate beyond the locus of the original injury.

While there is much the medical community does not understand about the etiology and nature of CRPS, the report of migratory symptoms ranks among the most controversial and baffling manifestations to confound the experts who study this condition. Some physicians, for example, believe there may be neuro-physiologic explanations for the migration of RSD up and down the sympathetic nerve paths along the spine, but they hasten to note that no similar mechanism exists to explain the migration of non-RSD CRPS. In such cases, they believe other mechanisms such as psychological factors may be at work. Other physicians believe RSD and CRPS can migrate, but disagree over the area of migration; some contending that the migration is limited to the area around the site of the original injury, while others believe that pain can spread to parts of the body far removed from the site of the original injury. In this case, Knight alleges that whether the condition is RSD or CRPS it has spread to his entire body.

Background and Subjective Symptoms

At the time of the hearing, Knight was 41 years old, Tr. 370, had completed the eleventh grade and obtained a GED. He testified that he was hired by Atlantic Marine as a carpenter and, over time, was promoted to shipfitter. Tr. Tr. 372; 493.

He recalled that, following the injury to his knee, he was treated conservatively with therapy for awhile, but the pain and swelling persisted and he was referred to Dr. Hardy for an orthopedic consultation. Based in part on the results of an MRI, Dr. Hardy scheduled him for surgery and performed it on June 30, 1995. By mid-July, 1995, Knight was back performing light-duty work, Tr. 614, and remained employed until the Fall of 1995, when he noticed that the pain, which began in his left knee, had migrated from his leg to the hip into the back. Tr. 608; Tr. 611-612; Tr. 613. Knight testified that he believes that original injury caused some tearing of the cartilage, damage to the surface in the middle of the left knee, and triggered reflex sympathetic dystrophy. Tr. 376.

The degree and scope of symptomology Claimant allegedly experiences is described in detail in his testimony and in statements he prepared and submitted into evidence at the hearing. Knight testified that his pain is severe and constant and effects every aspect of his life. His sleep, he claims, is constantly disturbed by pain, spasms, choking, lack of circulation, skin sensitivity, change in body temperature, and difficulty breathing. "Just air movement" causes pain, and any noise or light wakes him up. He experiences constant skin pain in the form of a "burning" sensation aggravated by stress, touching, stretching, or friction. He reports that he wears minimal clothing around the house and desires special apparel "preferably very fine silk... with few seams...," and "fine silk linens and down pillows."

Knight states that he sometimes experiences choking and throat spasms which allow him to consume only liquids. His medications, he claims, make him groggy, weak, sluggish, and sometimes cause hallucinations and nightmares. "Medication side effects, such as ringing in the ears, migraine headaches, light sensitivity, digestive disruption, frequent urination, nausea, dry mouth, itching eyes, sinus and skull pressure, leg, shoulder, and neck swelling, all interfere with sleeping." His hands, feet, and toes repeatedly grow numb and painful, and he describes severe skin pain and pain in his chest, hips, shoulders, ribs, knees, back, sterum, and neck. Extra activity such as vibration from traveling in a car, he relates, "overload" his nerves causing pain for hours or days. He reports that his "thinking skills, concentration, and memory" are diminished and he suffers depression, irritability, and fear.

Knight claims that simple body-stretching causes excruciating pain, cramps, and stabbing, spreading shocks and a burning sensation. "Even sitting causes pain in

the buttocks and thighs." He describes difficulty bathing and using the toilet, and "friction from gripping the faucet handles causes burning and bruising pain from the pressure of the hard handles." He claims he needs special towels, soaps, faucet handles, shampoos, has trouble turning keys in locks, and combing his hair. He reports that his scalp is painful and his fingers are so sensitive that his hair feels like the bristles of a sharp wire brush. Even his fingernails and toenails are painful when clipped. He endures "constant severe never ending pain." CX.W; CX. X.

In oral testimony and written statements, Knight describes the difficulties he experiences trying to use his wheelchair in a bathroom not large enough to accommodate it. He reports that he is chronically ill from colds, flu, and infections, experiences skin rashes and atrophy, jaw and skin pain from shaving, nausea and gagging from brushing his teeth, hand and finger pain triggered by twisting off jar caps or using utensils, washing dishes, or disposing of trash, and pain while attempting to dress. He experiences pain wearing shoes and pain when he steps on anything hard while barefoot. Cold weather, cold objects, and moving air cause him pain. Using crutches, operating his wheelchair, and sitting for long periods of time without a special cushion or being able to get up and move around, he claims, aggravates his pain. Any extra activity, he states, causes severe aggravation of the pain in his hands, fingers, palm, thumb, wrist, and forearms. At times, he feels "a deep pain like a hot poker" in his left hip joints, and severe pain in his shoulders, and shoulder blades, neck, throat, jaw, face, nose, sinus, temples, skull, and eyes. On days when his pain and sensitivity are high, Knight testified that the pain relief afforded by his medications "only lasts a few hours." Similarly, treatment he receives several times a week from Drs. Green and Fralicker, his treating physicians in Jacksonville, provide short term relief. Tr. 616. Benefits of treatment administered by Dr. Hooshmand, his treating physician in Vero Beach, last, he claims, anywhere from a few days to a few months. Tr. 579-80.

In addition to the whole-body pain he describes, Knight also reports that the RSD is effecting his memory and concentration with profound results. He claims, for example, that he must avoid cooking because he repeatedly forgets things on the stove creating a fire hazard, Tr. 401-02, and he has noticed an inability to recall thoughts at various times. He reports that he tried to cook a meal, "and as soon as I turn around and walk away from the kitchenette side of the apartment, I forget that it's on the stove until it caught fire." He notes that "it's uneven, but a common thing that happens is I can read something and by the time I get to the bottom of the page, I can't remember what I've read." Tr. 401. Knight possesses a valid drivers license

with no restrictions until December, 2006, but claims he loses concentration when driving. Tr. 408; Tr. 488-89. He reports that reading is often impossible, and he "has trouble even remembering where he stopped or what he read...." CX.W. Allegedly, he "... forgets a thought before he can write it down..." forgets why he moved from one spot to another in his apartment or what he "wants done, for errands or shopping." CX W. His memory is so bad, he claims, that he even forgets to read notes written to jog his memory, and "has difficulty putting thoughts together and communicating effectively." See also, CX. DDD at Tr. 98-99. Knight reports that diminished mental ability leaves him "unable to compose clear thoughts and speech," and that throat spasms and hoarseness prevent him from speaking "for days at a time," and often when he speaks "no sound occurs." CX.W. See, Tr. 49-52; Tr. 96. See also, CX. X pg. 8. Against this background of subjective symptomology, the parties adduced a substantial volume of medical evidence.

Medical Evidence

Following the injury at work and several visits to Baptist Occupational Health for physical therapy, EX 21, Knight, as menetioned above, was referred for an orthopedic consultation and further tests. CX. F. An MRI administered on May 26, 1995, revealed a moderate knee joint effusion and bone bruise, and on May 31, 1995, Claimant was returned to light duty indefinitely. CX. F. His condition, however, did not improve.

The record shows that on June 14, 1995, Knight was examined and treated by Dr. Hardy, an orthopedic surgeon who diagnosed an effusion and administered injection treatments. When the condition failed to subside, Knight returned to Dr. Hardy on June 21, 1995, with symptoms of pain and swelling, and Dr. Hardy scheduled him for arthroscopic surgery on June 30, 1995. CX. F.

As scheduled, Dr. Hardy performed a chondroplaty and an extensive synovectomy on June 30, including debridement of fat pad and plica of the left knee, CX. G, and Knight returned to light duty on July 10, 1995. CX.F. Dr. Hardy noticed, however, that Claimant was not recovering normally after the surgery. He originally anticipated that Knight would return to full duty by the end of July, 1995, The surgery, however, did not improve Claimant's condition. On September 7, 1995, Dr. Hardy noted that Knight made no progress in physical therapy, and had developed a "clunk" under the left patella. CX. G. About the same time, Dr. Hardy had decided not to provide Knight with new medications. Although Claimant

attributed that decision to interference by Dr. Knibbs, Dr. Hardy explained he unilaterally determined that further new medications were medically inadvisable because none that he had prescribed made "any real difference." CX. G.

Indeed, although Dr. Hardy's notes following the surgery contain no mention of swelling or pain migrating to other area of Claimant's body, Tr. 697, by September 28, Knight was reporting a stabbing pain on straight leg raising. On October 26, Dr. Hardy observed that the degree of pain Knight was reporting was "unusual compared to the pathology," and he referred him to Dr. Tandron, also an orthopedic surgeon, who examined Knight on October 31, 1995. Tr. 647-48; 683. CX. G. At the time of this referral, the medical notes of Knight's pain complaints reveal that his problem was located in the area of the left knee and nowhere else. Tr. 698. No report of pain in the hip was noted. Tr. 698. Not until November, 1995, did Dr. Hardy note that Knight complained of the pain beyond the knee itself but even then it was still around the knee area. Tr. 699.

Upon examination, Dr. Tandron noted that Knight was experiencing sharp pain under the kneecap, was using crutches, and reported that the sheets at night "bothered the anterior aspect of his knee," CX. G. 15, and had both objective symptoms of RSD, such as hair growth patterns, increased sweating, skin coolness in one limb, atrophy, skin shininess, Tr. 708, and osteopenia, or bone loss, Tr. 665; 684, and subjective indications such as hypersensitivity to touch. Tr. 699. Based on these clinical findings, Dr. Tandron thought Knight had RSD, Tr. 683; 684,[1] and he suggested that Claimant undergo a bone scan and sympathetic blocks to rule out RSD. CX. G. Dr. Hardy thus reported on November 8, 1995, that Dr. Tandron believed that Knight was developing RSD and he agreed that RSD seemed to be the "probable cause" of his prolonged recovery. CX.G.

In response to Dr. Tandron's input, Dr. Hardy referred Knight to anesthesiologists, Drs. Kruse and Besser, for sympathetic block treatment of RSD. Tr. 650; CX. G. The record shows that two such blocks were performed, but the

physician who administered them, Dr. Besser, noted that they produced only a "minimal" response, and Dr. Hardy deemed these results highly significant.

[1] Dr. Hardy noted that varicose veins can cause limb coolness, Tr. 706, but he noted that Knight had many other RSD symptoms. Tr.709 .

He explained in testimony at the hearing that RSD is usually confined to one area of the body, and sympathetic blocks temporarily impede the abnormal nerve activity in the affected area. When combined with therapy, the combination can help the patient. Tr. 650. In addition, the blocks are both diagnostic. Tr. 651. In Knight's case, for example, a phentolamine block, administered intravenously, failed to produce an effect. In Dr. Hardy's opinion, this test "is the most certain test for RSD," and its lack of affect on Knight, according to Dr. Hardy, ruled out RSD by definition. Tr. 651.

While the nerve block data was negative for RSD, Dr. Tandron, on January 18, 1996, recommended a bone scan and suggested that Knight be referred to a chronic pain management program. CX. G. Dr. Hardy ordered a bone scan on March 27, 1996, which was later administered, CX. G, and interpreted by Dr. Weidenmier as showing multiple areas of increased uptake. EX 25. Although the bone scan was not normal and showed increased uptake, (Tr. 710), neither the scan nor the block, in Dr. Hardy's opinion, revealed results consistent with any variant of RSD he had seen. Tr. 657; 684. These data, considered as a whole, were not, in Dr. Hardy's opinion, diagnostic of RSD; however, he agreed that Knight had some type of CRPS and for treatment purposes he did not deem it useful to distinguish between RSD and CRPS.[2] Tr. 662; Tr. 664-65; 667; 689; Tr. 701-702. Tr. 690. In his opinion, Knight had either CRSP or a psychological problem or both, Tr. 692, and, in view of his failure to improve, Dr. Hardy felt there was little else he could offer him. Tr.662; Tr. 655-56; 671; 693. He, therefore, recommended a pain management program. Tr. 703.

Thus, Dr. Hardy, like Dr. Tandron, referred Knight to Genesis Pain Management Group because he thought Knight needed a multi-disciplinary approach with experts in different areas of pain management. By April 17, 1996, however, Knight had refused to participate further in the pain management program and had refused to receive any calls from the rehabilitation nurse. CX. G. Accordingly, during an office visit on April 18, 1996, Dr. Hardy informed Knight that he continued to recommend the pain management program and that if he refused to participate Dr. Hardy "unfortunately" would have "nothing further to offer Casper." CX. G; EX. 14. P. 23. Nor were Drs. Hardy and Tandron alone in their beliefs that a pain management program was the appropriate course of action at that time. Thus, Dr.

[2] According to Dr. Hardy, the only cause for CRPS here is the original injury or the arthroscopic surgery. Tr. 716. Dr. Hardy did not believe Claimant's varicose veins caused the problem. Tr. 718.

Hartwig, in a report dated August 26, 1996, after noting that Claimant's left foot was colder than the right, that his complaints were consistent with RSD, and his negative nerve block results, recommended, like Drs. Hardy and Tandron, that Knight be referred to a pain management center. EX. 24.

As previously mentioned, Knight briefly acquiesced to a pain management program, and Dr. Virgil Wittmer, a clinical psychologist at Brooks Rehabilitation, formerly Genesis Rehabilitation in Jacksonville, Florida, was one of the health professionals who saw him. Tr. 259. Dr. Wittmer testified at the hearing.

He first saw Knight on March 4, 1996, upon referral by Dr. Hardy for a comprehensive pain evaluation. Tr. 263. Dr. Wittmer performed a psychological examination, Anita Davis performed a physical therapy exam, and Dr. Jawed Hussain performed the medical examination. Tr. 264. Dr. Wittmer testified that he diagnosed a pain disorder with both psychological factors and a general medical condition, and deferred rendering an opinion on the presence of a histrionic personality disorder. He noted that Knight exhibited a chronic pain syndrome, but appeared to be coping fairly well. Knight's multi-dimensional pain inventory suggested to Dr. Wittmer similar pain severity as other patients with chronic pain, although the degree to which it interfered with Knight's life was much higher than the average person with pain. He assessed Knight's emotional distress was average compared to other chronic pain patients, and his general activity level as poor in comparison with the average chronic pain patient. Knight's coping strategies questionnaire indicated to Dr. Wittmer very poor self-management skills for dealing with pain and suggested that Knight perceives that the various behavior or cognitive strategies are not effective at controlling or decreasing his pain symptoms.

Dr. Wittmer interpreted Knight's profile as likely consistent with a histrionic style, but he specifically testified that he did not diagnose Knight with a histrionic personality disorder. He explained that there are multiple symptoms or multiple characteristics of histrionic personality disorder, and DSM-4 requires that a certain number be present before the diagnosis can be made. Tr. 296. A diagnosis of chronic pain syndrome rendered by an orthopedic surgeon predating Knight's on the job injury could, he opined, possibly be an indication of another feature of a histrionic personality disorder, and could re-dispose him potentially to chronic pain with other injuries, Tr. 301-02, but Dr. Wittmer testified that did not make a definite diagnosis of histrionic personality. See also, EX 27. He was convinced, however, that the August 5,1996 injury resulted in the chronic pain syndrome throughout his

body, but he found that Knight was looking for medical treatment as opposed to rehabilitation and had very limited motivation for comprehensive rehabilitation services. Given Knight's psychological profile and underlying denial, however, Dr. Wittmer expressed reservations that surgery or further invasive procedures, such as spinal chord stimulation or a drug administration system like the morphine pumps, would obtain a positive outcome. Tr. 290. In his opinion, Knight's profile complicated the outcomes of those types of procedures. Accordingly, he recommended a limited physical therapy approach, Tr. 284-85, which did not, he testified, require Knight to suspend taking medications. Tr. 293-94.

The testimony of the psychologist was supplemented by Anita Davis, a physical therapy who also testified at the hearing. On March 4, 1996, she participated with Dr. Wittmer in a comprehensive pain evaluation of Knight. At that time, Knight was walking with crutches and was not using a wheelchair. She noted that Knight exhibited minimal pain behaviors and demonstrated less pain intensity behavior than other patients she had served. Her concern at the time was the extent to which Knight was de-conditioned as a result of the injury, and she recommended individualized physical therapy to increase his activities, increase his comfort in sleeping or sitting positions, strengthen his upper extremities, and improve his endurance.

Based, in part, on her evaluation, Genesis, in March, 1996, received authorization to pursue the individualized physical therapy she recommended. Davis testified that Knight attended one physical therapy session in April, 1996, and she did not hear from him again. Although she acknowledged that she did not personally witness the interaction between Knight and the doctors at Genesis, Davis confirmed Dr. Wittmer's testimony that it was not the policy of Genesis to require patients to go through physical therapy without medication. To the contrary, Davis testified that it was Genesis's policy to encourage people to maintain the medication routine established by their physicians. See also, Ex 27.

Dr. Harry Koslowski specializes in neurology, rehabilitation, and pain management, and treats patients with RSD. Dr. Koslowski testified at the hearing that Knight was referred him on September 4, 1996, for a determination of whether he had sympathetically maintained pain, RSD. Dr. Koslowski confirmed that RSD and CRPS can migrate throughout a limb but rarely moves to other parts of the body. With RSD, he opined, it can migrate along the sympathetic chain, affecting the nerves along the sympathetic chain, but he testified it would be difficult to explain

migration of CRPS. There is, in his opinion, no valid scientific, statistical or medical basis, from a neurological or patho-physiologic standpoint, for the spreading of non-RSD type CRPS, and from a neurological standpoint he ruled out the prospect that Knight had sympathetically (RSD-type) maintained pain. The protocol he used to rule out sympathetically maintained pain is called a phentolamine block, and he administered it at Memorial Medical Center on October 15, 1996.

In his report dated October 18, 1996, Dr. Koslowski interpreted the block was negative for RSD; and he referred Knight to Genesis Rehabilitation for therapy. Ex 26. Dr. Koslowski explained that a block is performed in the recovery room where the patient is given medications by I-V, and pain levels are monitored. The patient is unaware of drugs being administered; and may respond to a lactated ringer, a saline solution, Inderal, or to phentolamine, a reversible alpha antagonist which blocks the sympathetic chemicals and is, Dr. Koslowski testified, the actual drug which induces the pain relief. Dr. Koslowski explained that he observes the patient's response to the drugs, such as, with the Inderal, a decline in the heart rate or blood pressure, and with the phentolamine, temperature changes and nasal stuffiness.

In Knight's case, he administered lactated ringers, or salt water, and noted no change in pain or temperature. Similarly, with one milligram of Inderal, Knight's blood pressure did drop but there was no change in his pain. After the Inderal, he administered the phentolamine, 35 milligrams intravenously, which caused nasal stuffiness and a slight, but, in his opinion, adequate increase in temperature in Knight's left knee from 25.5 degrees Celsius to 26.5 degrees Celsius, thus confirming an adequate sympathetic block from the phentolamine. The phentolamine, however, induced no change in Knight's pain.

Based upon the results of a physical examination which yielded, *inter alia*, a pinprick response which Dr. Koslowski found made no sense, and Knight's response to the block, Dr. Koslowski advised Knight that he did not believe Knight had RSD. He further explained that with CRPS, as opposed to RSD, no sympathetic response would be expected, and the block would produce no temperature changes. Knight's block, however, did produce temperature changes, but it did not affect his pain. Dr. Koslowski thus reasoned that the sympathetic chain was working and some other mechanism was causing this pain. He recommended that Knight start aggressive pain management and vocational rehabilitation, and he referred him to the Genesis Outpatient Rehabilitation Center.

When asked at the hearing to consider the results of thermogram data, Dr. Koslowski testified that procedures like thermography are invalid because they yield too many false positives, and he questioned any diagnosis which placed reliance on such data. Similarly, he noted that while the single phase bone scan showed multiple areas of increased uptake, he opined that such results could be due to an arthritic process, and as such, is but one factor to consider in rendering a diagnosis.[3]

Dr. Claudio Vincenty, a Board Certified anesthesiologist and specialist in the field of pain management at the Jacksonville Spine Center, testified at the hearing and prepared a report. He was Claimant's treating physician for about three months. Dr. Vincenty first saw Knight on November 19, 1996, and formulated a plan to provide him with a lumbar sympathetic nerve block under CT scan. In his opinion, Knight had "classic symptomology" of RSD of his left leg. See, EX 18.

He explained that the sympathetic nervous system is a structure of nerves which generally lies right in front of the spinal chord but the exact position varies from person to person. Fluoroscopy and CT scan techniques allow the physician get a three dimensional image to mark the angles, length, and place to insert the needle with the minimum of trauma.

On December 3, 1996, Dr. Vincenty performed a block which Knight reported improved his condition about forty percent. In testimony, Dr. Vincenty recalled administering two blocks, (but see, EX. 22,) and noted that Knight experienced some weakness in his leg and groin numbness. Knight claimed he had been abruptly moved from the CT scan table at the time the nerve block was performed and believed that could have caused some of the medication to spill over into the nerves that go into the leg. Despite the numbness, however, Dr. Vincenty testified that the results of the nerve blocks indicated that a phenol block, which introduced a type of alcohol which destroyed the nerve, would be indicated.

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[3] Dr. Weidenmier performed a bone scan on April 2, 1996, which showed increased uptake in the left lower extremity, and which was interpreted in a July 15, 1997, as consistent with RSD in left lower extremity which could be bilateral. Subsequently, Dr. Erbug interpreted a November 30, 1999, total body bone scan as "Normal." Dr. Weidenmann observed in a report dated December 15, 1999: "Previously seen abnormal activity along both extremities on the previous bone scans dated 4/02/96 and 7/15/97 is no longer seen. However, there is only minimal visualization of the bone structures of the of both lower extremities...." CX. BBB.

Dr. Vincenty testified that Knight did not undergo the recommended phenol block, but instead, wanted him to follow some protocols Knight had researched on the Internet, EX. 18, which Dr. Vincenty did not consider a prudent course of action. In Dr. Vincenty's opinion, Knight exhibited "manipulative behavior" and indicated he could no longer treat him, EX. 18 at 9, but he did not believe Knight was a malingerer. To the contrary, Dr. Vincenty thought that Knight would benefit from a multi-disciplinary pain management approach, and Dr. Roger Green, an anesthesiologist and pain management specialist, following a review of Knight's condition, concurred in Dr. Vincenty's recommendation. EX 23.

The record shows that Dr. Jacob Green initially evaluated Knight on June 30, 1997, and has remained a treating physician ever since. Dr. Green is Board Certified in Neurology and pain management. In his initial report, he noted that Knight complained of burning pain from hips to toes at level 7-8, and "problems with chest, arms, and shoulders." CX. M. Dr. Green, upon examination, detected left leg atrophy and found that Claimant's left leg was whiter and cooler than the right leg. He diagnosed RSD, recommended "aggressive therapy," and suggested that Knight see Dr. Hooshang Hooshmand in Vero Beach. On July 8, 1997, Dr. Green prescribed Talacen and bracing "that he Knight Suggested," and on July 9, 1997, Dr. Green interpreted electronic thermographic images as consistent with RSD.[4]

On July 11,1997, the therapy recommended by Dr. Green was approved by the carrier, and on the same date, Dr. Green suggested, among other options, that Knight see Dr. Michael Stanton-Hicks at the Cleveland Clinic. CX. M. Shortly thereafter, Dr. Wiedenmann, on July 14, 1997, interpreted a bone scan as indicative of osteopenia around left femur, knee, ankle, foot, which he found consistent with RSD which "could be bilateral." CX. M.

At his deposition, Dr. Green recounted that on July 17, 1997, Knight asked him for Dr. Kovorkian's phone number, which prompted Dr. Green to counsel Knight against suicide and refer him to Dr. Lucas, a psychologist. Depo. at pg 19-20. By late July, 1997, Dr. Green again recommended that Knight see Dr. Hooshmand and prescribed a hospital bed.

Shortly thereafter, Knight visited Dr. Michael Lord, and orthopedic specialist, for an examination on August 7, 1997. In Dr. Lord's opinion, Knight was

[4] The Employer, in its post-hearing brief at page 10, advises that Knight participated in an NIH study in June of 1997. It does not, however, appear that the NIH study was entered into this record.

incapacitated in the left lower extremity by RSD, but he placed no restrictions on Knight's activities. CX. HH. On August 8, 1998, Dr. Lord removed from Knight's left hand a cyst which Dr. Lord thought was likely due to the use of crutches. CX. DD. Dr. Green had approved the hand surgery, (CX. DD), Dr. Hooshmand recommended against the cyst surgery and he wanted Knight to stop using crutches. Dr. Hooshmand eventually deferred to Dr. Green because he "is head of the treatment team and whatever he decides of treatment modalities is the final word." CX. DD pg. 33; 35.

Between May and August of 1998, Drs. Green and Fralicker prescribed a blood pressure monitor, a hot tub spa, See, CX. KK and CX. XX, and reported that Knight wanted a referral to an endocrinologist.[5] On July 28, 1998, Dr. Green again recommended that Knight be authorized to see Dr. Stanton-Hicks who he described as "the greatest expert in this disorder." Dr. Green believed that it would be in Knight's best interest if he could consult with Dr. Stanton-Hicks.

For the next several years, Knight visited Drs. Green and Fralicker fairly regularly for treatment of what they diagnosed as broadened CRPS. CX. CC; CX. GG.[6] On September 4, 1998, Dr. Green again diagnosed CRPS and examined a skin rash which Dr. Bruce Paley, a Dermatologist, subsequently biopsied on July 14, 1999, CX. CC. From time to time, Dr. Green recommended that Knight wear 100% cotton shirts, CX. CC, opined that Knight needed daily activities support 21 hours per week, soft towels, pillow liners, (CX. HH), calcium, Zebar, Ensure, special gloves, Epson salts, electrodes and supplies for his TENS unit, Herbiclens and antibiotic ointments. In January, 2000, Dr. Green opined that CRPS caused immune disorders warranting a flu shot. CX. EE. On July 19, 2000, he noted "a new development" manifested by sweatiness and burning due to anxiety as a consequence of paperwork required by the carrier, CX. CC, and observed that Knight was "losing ground" by August 24, 2000. By November, 2000, Dr. Lord found positive signs of shoulder impingement due to Knight's use of crutches and recommended physical therapy to strenghten his shoulders.

After about three and a half years of treatment, Dr. Green, on January 5, 2001, reported Knight's pain was still at level 8, and concluded, on February 23, 2001, that

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[5] On August 6, 1998, Dr. Roura, an endocrinologist, attributed Knight's calcium problems to RSD not a parathyroid status. Ex. N.

[6] The record shows that between April of 1999, and March of 2002, Knight visited Dr. Green 56 times, and Dr. Fralicker 198 times, and, in addition, treated with Drs. Hooshmand and Hashmi 52 times.

he suffers a "total body impairment." CX. FF. On October 19, 2001, he described Knight's condition as static for about three years: "there is little else we can do except keep giving him medication and hope for the best." CX. M. By then, the Employer had suspended Knight's benefits, and Knight was telling Dr. Green that he was suffering from memory loss. Dr. Green, in trun, reported that the memory loss was possibly due to involvement of cerebral vessels with the CRPS or a reaction to medication. CX.CC. Knight continued to treat with Dr. Green, who, from time to time, continued to prescribe physical therapy, a high voltage galvanic unit, a motorized wheelchair, CX. DD pg. 31, a hot springs type of spa, chiropractic treatment 3 times per week for 6 months, and wheelchair access for his personal residence. CX. M.

When requested to consider an infusion pump as an alternative to the treatments he had been administering over the years, Dr. Green observed: "Patient has been offered a pump. In my experience...these pumps have been dismal failures with great complications. I would advise against it ...but would defer to Dr. Hooshmand who I think would, of course, agree that these pumps are disastrous." CX. EEE. As discussed below, however, Dr. Hooshmand did not agree.

Finally, it should be noted that in March, 2002, responding to Employer's request that Knight undergo an IME and FCE in Tampa, Dr. Green opined that Knight, who traveled frequently to Vero Beach to visit Dr. Hooshmand, could not make the shorter trip to Tampa without pain treatment before and after the journey. CX. M. Taking Dr. Green's opinion into account as fully presented by Claimant's counsel during a pre-hearing conference, Knight was ordered to attend the FCE in Tampa, but the Employer was ordered to see to his medical needs before, during, and after the trip in accordance with Dr. Green's concerns. Before departing for Tampa, however, Knight returned to Dr. Green on May 1, 2002, and obtained a note which Knight took with him and presented to the physicians in Tampa. In it, Dr. Green redirected the focus of his concern from the need for pain treatment before and after the trip to a new objection directed at the FCE itself. Dr. Green wrote: "FCE can be dangerous. Not prescribed." CX. L; CX. UU. In Dr. Green's opinion, Knight is permanently and totally disabled, wheelchair bound, and, therefore, he deemed an FCE unnecessary. CX. UU.

Dr. Deborah Fralicker is a Doctor of Chiropractic, CX. I, who first saw Knight on July 10, 1997, on referral from Dr. Green. She was deposed on October 11, 1999. CX. L. She testified that she diagnosed Knight with RSD due to his work-related injury, assessed him at MMI with deterioration from crutches to wheelchair, and in

need of home aid. In her opinion, Knight is permanently and totally disabled, cannot sit in one position for more than ten to fifteen minutes, and "He also has very poor concentration due to his pain level as well as weakness."

Dr. Fralicker has treated Knight with gentle manipulation, infrared photon stimulation, and acupuncture. She has, from time to time, recommended that he be given a jacuzzi spa at home, CX. L, March 31, 1999; that Knight see a dermatologist for a rash on his upper torso, back and chest, CX. L, April 16, 2001; and recommended physical therapy three times a week, including moist heat, electrical muscle stimulation, strengthening exercises for the calf and left quadricepts, massage for 30 minutes three times a week, and acupuncture.

The record shows that during virtually the entire five-year period Drs. Green and Fralicker treated Knight, he reported pain levels above level 7 which, over time, spread from his left knee to other areas of his body including low back, mid back, fingers (See, CX. DD), sternum, shoulders, neck, hip, hands, head, and skin, while his condition deteriorated from crutches to a wheelchair.

Dr. Majdi Ashchi, a doctor of Osteopathic Medicine, saw Knight for vasospastic angina in June and July, 1999. Tr 154-55. On September 22, 1997, Dr. Green attributed the Vasospasms to the RSD, a conclusion Dr. Ashchi shared on February 7, 2001, when he opined that a cardiac catheter showed "normal coronary arteries," CX. O, but mild spasms in the LAD which could be vasospastic angina, CX. UU; See also, Ex. 19, "most likely due to RSD." Dr. Ashchi prescribed nitrates and calcium channel blockers. CX. O.

Dr. Hooshang Hooshmand is Board Certified in Neurologist and Psychiatry (CX. SS; see also, CX. WW). He was deposed on May 26, 1999, CX. Z, and again on May 15, 2002. CX. DDD. Employer authorized Dr. Hooshmand but did not select him. Tr. 26. He first saw Knight on August 5, 1997, on referral from Dr. Jacob Green. Dr. Hooshmand's office, as previously mentioned, is located in Vero Beach, Florida, and Knight travels from his home in Jacksonville staying over night for several sequential days to see him. CX. DDD at Tr. 71.

Dr. Hooshmand noted that the original injury was limited to the left knee but the RSD migrated to all extremities and the back by the time he saw Knight. Depo at Tr. 22. Dr. Hooshmand relied upon infrared thermography as showing the spread of RSD to upper extremities. CX. TT. Dr. Hooshmand seemed to concur, at least in part, the mechanism of migration for RSD discussed by Dr. Koslowski. He noted

that the sympathetic system has two chain of ganglion on each side of the spine and an irritation at one point can cause a chemical irritation that travels up and down the chain. CX. DDD at Tr. 157.

In Knight's case, Dr. Hooshmand observed hyperpathic or algogenic pain, i.e. regional pain; constriction of blood vessels or muscle spasms; (cold extremities; increased blood pressure upon touch); immune system disturbance; and Limbic system disturbance (frontal and temporal lobes effected) which he described as all diagnostic of RSD. CX. DDD at Tr. 93. He considers bone scan tests unreliable and uses thermography instead, CX. DDD at Tr. 94, because, as he explains, there are two different kinds of pain; sympathetic maintained pain and sympathetic independent pain, and the distinction is detected by thermography; the latter showing up hot, the other cold. CX. DDD at Tr. 136. He diagnosed stage 3 RSD based upon blood pressure comparisons, vascular changes detected by temperature variation, inflammation; emotional disturbance which Knight "has plenty of," and muscle atrophy around the left knee. Tr. 24-26.

Dr. Hooshmand's report of September 30, 1997, noted Claimant's history of angina and the results of the cardiac catheterization, CX. O, noting that with somatic pain there is no vascular or microvascular involvement, Tr. 19-20, in contrast with RSD which causes swelling due to irritation of the sympathetic nerves in the walls of the blood vessels. Tr. 20. At time of his 1999 deposition, Dr. Hooshmand noted that Knight was capable of bearing weight but was, contrary to Dr. Hooshmand's advise, using crutches. Tr.21. In Dr. Hooshmand's opinion, Knight's conditions, including his chest complaints, reduced immunity, skin problems, poor concentration and memory, and loss of sleep are all caused by the
May 8, 1995 injury and were aggravated and perpetuated by the knee surgery. CX. DDD at Tr. 35; Tr. 39; 41- 44.

In Dr. Hooshmand's opinion, Knight should remain as active as possible. He prescribed various medications including Stadol a narcotic nasal spray, Tr. 31-32, which was later switched to Buprenex, Tr. 38; Trazodone, an antidrepressant; Baclofen; a muscle relaxant; Clonidine patch, an alpha blocker to block input to the sympathetic nerves; xylocaine cream, to counteract hypersensitivity; active physiotherapy at home. In addition, the record shows that Knight visited Dr. Hooshmand three or four days every two to three months. Tr. 41. In-office treatments included nerve blocks, marcaine and Depo-medrol, a steroid. Tr. 36. Dr. Hooshmand reported that the injections, administered every 8-12 weeks kept the

condition under control and provided excellent short-term relief, but yielded no improvement of the condition itself. Depo at Tr. 37; see also, CX. TT.

Dr. Hooshmand testified that Knight's treatment plan remained constant, Tr. 48, except when he switched the Buprenex to a sublingual form, Tr. 48, 56, which is a higher dose than the injected form because stomach acid tends to neutralize the medication. A Buprenex dose is .3milligrams when injected but .9 to.12 when sublingual to compensate for acid breakdown. CX. DDD at Tr. 88. He also added Soronon cream; an antidepressant, Tr. 52, Lido-Tetracaine cream; Hydroxyzine for nausea, Tr. 56; and Hydrolizine for blood pressure.

By 1999, Dr. Hooshmand was reporting that Knight was doing much better both emotionally and physically. Depo, at Tr. 59-60. He observed that spreading RSD is uncommon, but that he had seen it before, Pg. 31-32, and, in his opinion, Knight's had migrated. Tr. 33. He noted that some atrophy had not completely cleared up, but Knight was not getting better or worse, and was "almost at MMI." Tr. 60. In Dr. Hooshmand's opinion, an infusion pump which administers morphine, Dilaudid or other pain medication, "is best chance for relief" and may be Knight's "Only hope." CX. DDD at Tr. 61-64; CX. DDD at Tr. 53. Dr. Hooshmand's experience with RSD patients on pumps, unlike Dr. Green's, showed a success rate of 90% on pain in lumbar region, 50% in thoracic, and 35% in neck region. Tr. 63. "When a condition is so out-of-control and is so damaging and severe... try to contain it," and as a last resort he recommends an infusion pump. CX. DDD Tr. 37; Tr. 38-9. In Knight's case, Dr. Hooshmand reported that; "All we can hope for is two things. Number one, keeping it from getting worse; number two, with help of infusion pump, giving him medication," pain relief. CX. DDD at Tr. 48-49.[7]

In Dr. Hooshmand's opinion, the pump is the "only hope he's got left.... That is my strong belief." CX. DDD at Tr. 113-114. He discussed pump with Knight, and detected no "objection to it." CX. DDD at Tr. 117. Dr. Hooshmand testified; "I believe it is the sensible thing to do, to try the pump.... (Tr. 118), "If the pump does not agree with patient, it is reversible." Tr. 120. According to Dr. Hooshmand, "Actual implantation is not invasive at all," Tr. 122, and there is "no need for transfusion, so no problem with Jehovah's Witness beliefs." CX. DDD at Tr. 123. In addition, in his opinion, facility-oriented physical therapy is not medically

[7] Considering his needs, Dr. Hooshmand opined that a jacuzzi hot tube is not necessary. See, Tr. 68. CX. M.

necessary for Knight, Tr. 73, and he recommend against it. Tr. 74. Nor did he believe that Knight needed a full blown spa; "I believe a bathtub with jets would do it." See, Tr. 68; 78-79; CX. M. Nor did he see a continuing need for chiropractic treatment. CX. AA. On September 7, 2000, Dr. Hooshmand suggested that a vocational rehabilitation evaluation and "non-traumatic FCE" could be performed by March of 2001. CX. AA.

Over the next twelve months, Knight reported to Dr. Hashmi, an associate of Dr. Hooshmand, the his pain levels ranged from 8 ½ to10. On January 19, 2002, Dr. Hooshmand rated him totally disabled and rated his condition as permanent since February 23, 1998. CX. AA, pg.67; CX.TT. In a report dated January 17, 2002, Dr. Hooshmand observed that confrontations with carrier's representative aggravates Knight's CRPS which is a "disease of stress (distress)." CX. TT. He also observed that because Claimant's deposition was not limited to periods of 45 minutes with rest periods, he had pain, headaches, and blurred vision; "Due to 5 hours of inactivity(deposition), he has developed the classic signs of allodynia, which is common in CRPS patients who have been inactive." CX. TT. He can drive short distances at his own discretion. CX. TT Pg 9.

Dr. Hooshmand further warned that Claimant's condition "is aggravated by too much rest or too much activity as well as stress." CX. TT. Indeed, Dr. Hooshmand commented on May 20, 2002, that any job that "required sitting 100% of the time is harmful, it could do more harmful than constantly moving around. He should frequently change position with resting intervals and moving intervals alternated," CX. CCC. Significantly, Dr. Hooshmand reported; "He should be in perpetual motion, finding a position that does not cause pain." CX. DDD at Tr. 111. "The moment you spare the patient from surgery, and ice and casts and immobilization and wheelchairs they're going to have success." Tr. 69.

According to Dr. Hooshmand, sedentary work is dangerous for RSD patients because they must move around a lot. CX. DDD at Tr. 156. He noted that the work restrictions reported on May 20, 2002 were valid, CX. DDD at Tr. 48, and if a job could be found that accommodated those restrictions then Knight is employable. CX. DDD at Tr. 112. Noting concerns expressed by other physicians regarding Knight's polypharmacy, Dr. Hooshmand opined that Knight does not need detoxification at this time because Dr. Hooshmand claims he detoxified him years ago. He also opined that the Bupenex, although a narcotic, does not cause addiction. CX. DDD at Tr. 46.

On April 22, 2002, Knight went back to Dr. Hooshmand with symptoms of swelling and spasms in throat, tongue swelling; sleep loss, gaging and vomiting. CX. ZZ. Knight reported; "Terrible concentration and memory," and told Dr. Hooshmand he may forget he is cooking. Dr. Hooshmand obtained a thermograph which he compared with a December 24, 2000, thermograph and interpreted it as showing "deteriorating health and increased pain..." CX. AAA. By April of 2002, Knight appeared wheelchair bound, and Dr. Hooshmand rated him "78% whole body impairment and totally dependent on wheel chair, and 100% permanent." CX. TT; CX. DDD at Tr. 50. Dr. Hooshmand recommended special housing modifications such as modified doors, ramps, cabinets, wheelchair special tub, stools, rails, crutches, (CX. DDD at Tr. 53-4; 55,), and home aid 6-7 hours a day six days a week. CX. DDD at Tr. 52.

Dr. Michael T. Pulley is a neurologist, the director of the EMG lab at Shands Hospital in Jacksonville, and an assistant professor of neurology with the University of Florida. He reviewed all of Knight's records, but did not examine him. Dr. Pulley testified: "I don't think there's any debate" that Knight has RSD in the left leg caused by the left leg injury. Dr. Pulley prepared a written report, EX. 20, and testified at the hearing. In his practice, he has treated ten to fifteen patients who had RSD or CRPS, and noted that he has no specific treatment protocol and addresses each patient individually.

Dr. Pulley opined, unlike Dr. Koslowski, that a phentolamine block which produced no change in pain response would not necessarily rule out RSD or CRPS. He testified; "I do not think that you can rule in or rule out the diagnosis based on that test." In his opinion, whether Knight has CRPS or RSD is not important, because, "everybody accepts that Mr. Knight is in pain, and that he needs treatment for pain whether we call it complex regional pain syndrome or RSD, I think the approaches to the treatment of the pain are going to be very similar, regardless of what you call it. So the label is not as important as just accepting that the pain is there and you're trying to do something about it." Significantly, however, he did not believe pain in areas other than Claimant's left lower extremity was due to RSD or CRPS.

Dr. Pulley acknowledged that the area of dysfunction may spread beyond the original area of injury, so that "even if somebody stubs their toe and they don't injure their leg higher up, that there may be... dysfunction in, you know, parts that were not directly injured by the original event,... but it was still a localized problem, isolated

to either a limb or an area associated with traumatic pain that may be in a particular area of the limb." He testified that the question of whether RSD can migrate is a very controversial point, but "I think that there are cases in which there has been clear documentation of people developing what would be considered classic RSD in a limb that did not suffer the original injury." In Knight's particular case, however, Dr. Pulley further observed that: " I think it's not uncommon to see the effects spread to other parts of the same limb. I think it's extremely rare and extremely controversial as to whether it would spread to other parts of the body.... I do not think, my personal opinion, just based on reviewing records that the pain in the other parts of his body is likely to be due to RSD or complex regional pain syndrome."

With respect to Dr. Hooshmand's findings of improvement in Knight's case, Dr. Pulley noted that the assignment of percentage improvement for various aspects of Knight's problem, such as an eighty percent improvement of inflammation, lacks substantiation or a basis in any technique to measure the amount of inflammation present. Evaluating Dr. Hooshmand's treatments, Dr. Pulley observed; "It seems as though he may get some temporary benefit from the injections, but there does not appear to be any long term improvement." Similarly, he noted that Dr. Fralicker's claims of improvement attributable to her treatments with physical therapy and chiropractic manipulation are based on subjective language without any real objective measures. Dr. Pulley noted that:

> "The only real measures of Mr. Knight's pain that I had seen in any of the notes was the subjective description by Mr. Knight of his pain on a scale of one to ten. And his pain level from the very first visit to Dr. Jacob Green was a seven to eight. And also when he first saw Dr. Hooshmand in August of '97, it was again a seven out of ten. And in reviewing the pain scores that he described subsequent to that, none of them were ever lower than seven. So there did not appear to be any change in that number over time to indicate that there was improvement in his condition."

Indeed, Dr. Pulley questioned whether the repeated injections in various body regions may have contributed to the spread of Knight's chronic pain. He observed that, in reviewing the records in Knight's case, it seemed that the areas in which injections were administered may have preceded the spread of his pain to other parts

of the body: " It's not, you know, it's not totally clear whether the pain complaints in all instances preceded the injections into those various body regions."

Dr. Pulley noted further that it did not appear that injections provided any long term benefits. He observed no clear improvement in Claimant's subjective evaluation of his pain level at any time since he began receiving the injections. His pain level, Dr. Pulley noted, never dropped lower than it had been before he started receiving them, and although the records indicated that he got very good relief of pain when he got the injections, the relief was very short lived and not persistent. In Dr. Pulley's opinion, the relief was so brief that continued use of injection therapy seemed unwarranted.

Turning to the daily physical therapy protocols, Dr. Pulley, again, felt that there was no clear evidence of any lasting beneficial effect, but overall, Dr. Pulley was not inclined to consider the modalities of treatment administered by Dr. Hooshmand's or Dr. Green "...out of the realm of accepted treatments," and found the medications; "to be within sort of the realm of reasonable medications that might be used to treat chronic regional pain syndrome or RSD and none of the specific medicines were out of that realm...."

Nevertheless, Dr. Pulley noted that most patients benefit from mobilization, or use of the affected part as much as possible, and early and aggressive pain management along with anticonvulsants, antidepressants, and/or narcotics. Depending upon the particular modality, the treatment period would vary. For example, Dr. Pulley noted that antidepressants frequently take longer to have a therapeutic effect than the anticonvulsants. Anticonvulsants if they are going to work at all, often work almost immediately. Narcotics also work quickly, and injections, if they're going to work, take effect work quickly. In Dr. Pulley's judgment, a primary question in determining whether a particular modality, including physical therapy, is reasonable therapeutic option is the duration of effectiveness.

Dr. Pulley also reviewed Dr. Ashchi's treatment of Knight and analyzed the alleged causal relationship between RSD and vasospastic angina. After several searches of the medical literature for any reports of association between either RSD or CRPS with angina of any type, Dr. Pulley testified that he was unable to locate any association in the medical literature, and the cardiologic tests, as far as he knew, were not a diagnostic tool in the assessment of RSD. He acknowledged that he

would defer to a cardiologist who has experience with RSD patients in assessing whether spastic angina is aggravated by RSD, but he found no evidence in the literature which suggested to him any cause and effect relationship between RSD and angina.

Dr. Daniel Rowe, an anesthesiologist specializing in pain management and a clinical associate professor at Shands Jacksonville, testified at the hearing. He evaluated Knight on April 8, 1999, and concluded that Knight has CRPS type one, RSD, of the left lower extremity. See, EX 15. He explained that CRPS type one, previously called RSD, is a diagnosis achieved clinically after the patient undergoes a physical, a history, laboratory studies, and the Wilson diagnostic criteria for RSD which include the historical findings, physical and the laboratory findings, such as x-rays, results to nerve blocks, tests such as thermography, and sweat tests, among others. Each item is assigned a point. For example, if the patient has certain classic signs of RSD, such as burning pain in the affected extremity, one point is scored or if he exhibits extreme sensitivity to light touch known as allodenia, and a positive response to a sympathetic nerve block; that would be three points.

Considering all of the Wilson criteria, a number between zero and three, would, according to Dr. Rowe, indicate that it is unlikely that the patient has reflex sympathetic dystrophy; a number between three and six, RSD would be possible, and Wilson score greater than six, would indicate that the patient probably has RSD. Dr. Rowe testified that Knight "was over six very quickly. So there was no issue of the diagnosis in my mind of reflex sympathetic dystrophy." In addition, Dr. Rowe acknowledged the medical controversy over the notion that RSD can be migratory, but testified that, "In my practice, I felt over the years I had seen what I believe to be migratory reflex sympathetic dystrophy."

Dr. Rowe observed that there is a difference between pain associated with the sympathetic nervous system and pain that is not associated with the sympathetic nervous system, and Knight has a sympathetic nervous dysfunction. In Dr. Rowe's opinion, "Knight has, and not in his mind, but actually literally has an exaggeration of pain through a wider area than where the original injury was." In his fifteen years of practice treating about five hundred RSD patients, Dr. Rowe testified that he has seen two cases of migratory RSD, "and Knight is one of two cases" with pain in his shoulders, back, head, neck and elsewhere in his body.

Dr. Rowe assessed the treatment provided by Drs. Hooshmand and Hashmi as "absolutely thoroughly appropriate," but he noted that Knight, after a year and a

half of treatment, was not deriving any substantial long term benefit, and he thought that treatment alternatives should be pursued. Like Dr. Pulley, Dr. Rowe thought that continued steroids injections were inadvisable, and he suggested that Knight should begin a program of physical therapy in his own at home. In addition, in a report dated October 20, 1999, he expressed reservations about the need for Jacuzzi style hot tub recommended by Drs. Fralicker and Green, noting that the same benefit could be obtained by in a bathtub equipped with a heater and jets. EX 17. Dr. Rowe testified that 40% of Knight's pain is due to RSD and the rest is probably secondary to the primary internal derangement of the left knee. He thought Knight would benefit from spinal cord stimulation[8] and possible surgery, but in the absence of intervention he recommended continued medications.

Dr. Rodolfo Eichberg is Board Certified in physical medicine and rehabilitation and testified at the hearing. He was asked by the employer to perform a functional capacity evaluations (FCE) of Knight and prepared a report dated May 13, 2002, See, EX 33 EX 42. Dr. Eichberg testified that he has been conducting FCE's for twenty-seven years. Each FCE takes one or two days to complete and each is actually administered by a therapist under his supervision. He testified that an FCE can be conducted on an individual who has RSD and noted that the diagnosis itself is not a limiting factor. If the pain is under control, there is, according to Dr. Eichberg, very little that the therapist could do that would harm such a patient. Nor would the prescription for conducting a functional capacity evaluation differ for a patient with migratory RSD. The prescription for functional capacity evaluation generally reads functional capacity evaluation, and the physical and occupational therapists take it from there.

Dr. Eichberg evaluated Knight with "possible" RSD, left lower extremity, a qualified assessment because while Knight claimed to experience allodenia or

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[8] Dr. Rowe has utilized spinal chord stimulator systems in his practice. He described the spinal chord stimulation system as an implant device. He determines if the patient is a candidate for implantation with a brief trial of the devise. Using an epidural approach, the tip of the electrode with active leads are placed in the mid thoracic area for a patient with, for example, lower extremity problems. The electrodes emit a very tiny electrical current which literally, through neurophysiologic mechanisms, block the pain transmission deriving from the affected extremity and in place of pain, the patient perceives a pleasant tingling sensation.

The stimulator electrode is externalized through the skin to a power pack that the patient can control to turn it on or off and various parameters of the electrical current. The patient decides if they if they like it or not and fills out a flow sheet. At the end of the trial, it is decided if the patient is a candidate for full implantation. If the trial is successful, the patient goes on to full implantation and the entire device is implanted. The electrode is left in, but tunneled under the skin and the generator, which looks like a pace maker generator, is implanted under the skin. The patient then communicates with the battery pack through a telemetry control system.

enhanced sensation to a superficial stimulus, but Dr. Eichberg did not see the glossiness, discoloration, swelling, or abnormal distribution of hair which are characteristics of RSD. He testified that he thinks Knight does not have migrating RSD of the whole body, but has RSD of the knee. He further testified that he was unaware and did not believe that Knight suffered any significant preexisting injuries. Dr. Eichberg acknowledged that his function was to evaluate Knight's level of activity, level of function, and rehabilitation potential not to provide a diagnosis, and the extent of RSD fell within the scope of his function.

In Dr. Eichberg's judgment, a psychological overlay was a component of Knight's condition, observing that Knight's reaction to the RSD was "at least unusual." In twenty-seven years of practice, Dr. Eichberg noted that he had not seen a person with RSD need a wheelchair for any reason; "So if nothing else, this is an exaggerated response to the condition." Other psychological factors Dr. Eichberg observed include the medication Knight takes which "probably would put most mortals to sleep," and the patient history questionnaire which included Knight's drawing of his complaints involving the entire body with his written description, "Whole body, plus, plus" that Dr. Eichberg described as "highly unusual." Dr. Eichberg was unfamiliar with "any condition that would give you whole body pain, plus, plus." Indeed, Dr. Hooshmand, at deposition, seemed to concur, opining that pain can spread, but it is "impossible" to get total body pain. CX. DDD at 149.

Dr. Eichberg also evaluated a condition he termed, "polypharmacy," meaning many medications. Knight is taking a narcotic pain medication, a muscle relaxant, a hormone against osteoporosis, a tranquillizer, anti-nausea supplement to narcotics, an anti-vomiting drug, Nitrostat, Norvasc, an anti-hypertensive, a second muscle relaxant called Zanoflex, and a personalized, druggist-mixed lidocaine lotion. He explained that his impression of polypharmacy with possible physical and psychological medication dependence was a based on Knight's consumption of Buprenex administered sublingually in tablet form prepared by a pharmacist specially for Knight.

Dr. Eichberg also described Knight's inactivity and de-conditioning as "extremely destructive," and observed that Knight had a tendency to magnify his symptoms as exemplified by the ten or fifteen page written "summary" of his problems which he handed to Dr. Eichberg when he arrived for his FCE.[9]

[9] In addition, he handed Dr. Eichberg a note from Dr. Green indicating that an FCE was dangerous and was "not prescribed." As a result, Dr. Eichberg testified: "if somebody comes to my office with a note saying that a

Dr. John Barsa is Board Certified in pain medicine and testified at the hearing. He has treated RSD patients in his practice. See, EX 32. On May 9, 2002, he performed an independent medical evaluation of Knight. Ex 43. He reviewed Knight's typed twelve page description of his complaints and symptoms and performed a physical examination. Dr. Barsa noted inconsistencies in Knight's answers and noted that he became angry when questioned about his need for home aid, and again expressed anger at the employer commenting that "companies... need bodyguards and because of what they have done to him and other people, somebody may take a gun and go over their." p.2. He explained that Knight's FCE was not done "because of request by his physician not to do it for fear of flare-up of his RSD." P.13.

Significantly, Dr. Barsa reported; "Patient was observed for four hours. He was able to sit without having to stand. There was not much position shifting. He was observed to be able to move bilateral upper extremities freely. He was able to move his right lower extremity freely." Dr. Barsa concluded that Knight may have RSD in left lower extremity, but it has not spread to other parts of his body. P. 14. Among his impressions included persistent pain syndrome with multiple contributing factors including a combination of functional and organic components, and he considered it advisable to rule out chronic pain behavior, a somataform disorder which he described as one of the ramifications of the consequences of chronic pain that often occurs with patients. He explained that pain, over time, becomes a

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functional capacity evaluation is harmful, even if I disagree, I will not impose my concept on this person who is not even my patient. An independent medical evaluation is by definition, establishing no doctor/patient relationship. So I don't think that I was going to contradict that. And if somebody says it's dangerous and that person is involved in Mr. Knight's treatment, I got to respect that, even if I disagree."

He explained that he disagreed with Dr. Green because an FCE can be individualized and tailored to any patient's needs, including a quadriplegic, an amputee, or a stroke patient. He provided the example of an FCE administered to an individual with an eighty percent total body burn, totally disfigured with contractures in every body joint; "But you can say this person can do this, this and this. He can or he can not brush his teeth. He can or can not wash his face. I don't think there is any condition known to man where he can do absolutely nothing," and in Dr. Eichberg's opinion a tailored prescription for a functional capacity evaluation in Mr. Knight's case could allow it to be performed safely. Dr. Barsa added in testimony that it probably would be safer to perform an FCE in the hospital setting, "so that he doesn't have a heart attack, and get the capability assessment and evaluate the angina."

As a result of Dr. Green's note, Dr. Eichberg performed a physical examination not an FCE. Dr. Eichberg testified that he disagreed with Dr. Green that an FCE would be dangerous but he understood Dr. Green's note stating that "Functional capacity must be limited by patient's major disability, functional capacity evaluation can be dangerous, not prescribed," as an admonition not perform an FCE; "I interpret the two words not prescribed as meaning don't do it.... if somebody says, 'Dangerous, not prescribed,' I think that's enough for me." As a consequence, Dr. Eichberg performed only a limited physical examination.

behavior problem including frustration, anger, denial, and general preoccupation with pain which must be addressed. Dr. Barsa doubts that Knight has experienced a spread of RSD from the left lower extremity to other parts of his body, and noted that; "It's very rarely that we see RSD going on for several years and just getting worse, unless it's complicated by more iatrogenic issues. One of them is more and more pain medication and more and more placebos and so forth."

In his report dated May 9, 2002, Dr. Barsa observed that Knight's; "complaints of pain and dysfunction are out of proportion to organic findings and clinical presentation." Ex 31. In addition, Dr. Barsa thought it advisable to rule out substance abuse disorders and medication problems with a period of hospital inpatient pain evaluation and comprehensive treatment. Dr. Barsa acknowledged that he did not perform any drug testing on Knight, however, he concluded that the medication problem and possible detoxification needs to be further evaluated in a controlled environment. In addition, he considered a psychiatric assessment important, improvement in activity level essential, a trial to determine whether Knight is a candidate for an implanted pump advisable, and an evaluation to rule out primary and secondary gain as a factor impacting the Knight's complaints of pain and dysfunction appropriate. Dr. Barsa observed that "What is interesting in this gentleman, that as time passed by, the problem got bigger, the litigation got higher and the inactivity(sic) went way down. So instead of being able to walk to the mall and go grocery shopping, come back and be exhausted, lying down for two hours, he can't go to the mall. He is all the time in a wheelchair.... So when you look at the whole thing you see worsened magnitude, still pain nine or ten, even with the pain medication.... It's a dead end...."

Dr. Barsa believes that Knight currently does not need continuous attendant care, and while he found Knight unable to return to his previous employment as a shipfitter or ship's carpenter, he considered him capable of performing sedentary work on a part time basis as of the date of his examination on May 9, 2002. He testified at the hearing, however: "If you ask me would I send him back to work, the answer is no because there are factors, including the liability, the medication and so forth." Dr. Barsa reviewed a vocational report by Rick Robinson and concluded that Knight could not perform the two jobs it indicated may be suitable for him. He explained ; "I don't recommend work until the drug problem has been solved,"[10]

[10] Dr. Barsa testified that he believed "to a reasonable medical probability" that Knight has a drug problem.

however, he would not disagree with a trial run for a sedentary job consistent with Claimant's physical limitations. But see, CX. CCC; CX. RR.

Rick Robinson is a certified rehabilitation counselor with Momentum Health Care. He was assigned to Knight's case for vocational consultation in June of 2000. He testified that he tried on numerous occasions through February of 2001 to make contact with Knight without success. As a consequence, he reviewed the file which included information about Knight's condition, the treatment he had received, and the assessments, impressions, and restrictions placed on Knight by his treating physicians, including Dr. Pulley, Dr. Hooshmand, Dr. Green, Dr. Ashchi and Dr. Fralicker.

Drs. Pulley and Ashchi, he noted, provided no work restrictions. Drs. Green and Fralicker opined that Knight was unable to work, while Dr. Hooshmand had indicated that part time light duty jobs may be appropriate Knight. In addition, Robinson considered Knight's educational background and his employment history. He observed that in reviewing the medical records, Dr. Ashchi had noted that Knight, "is a very well versed person," and that "He uses the Internet," an observation also noted by Dr. Vincenty. As a result, Robinson concluded that Knight, in terms of special skills, has some computer skills or at least the knowledge of using the Internet, and authored on May 24, 2001, an article titled, "My Experience with Workers' Comp by Casper Knight." He also wrote a daily summary of RSD which Robinson reviewed. Robinson testified: "So in looking at those, I can really begin to develop at least a hypothesized vocational profile, which would indicate that he has computer skills. And you know, extracting that information, as well as watching Mr. Knight interact in this courtroom, that he has the ability to engage in clear, logical, cognitive processing of information and abstract ideas."

Robinson observed that Knight has "very good writing skills, and referred to an article entitled; " My Experience with Workers' Comp and RSD," written by Knight and posted on the internet by Dr. Green. Tr. 570. In Robinson's opinion, Knight "is clearly able to convey his thoughts verbally, and convey his ideas to others, very strong ability to conduct research," and considering his educational background and demonstrable ability to synthesize and present and understand

information, Robinson concluded that Knight is readily trainable in doing computerized research.

Based upon all of the foregoing information, Robinson prepared a labor market survey of Knight's geographic area, and contacted employers about opportunities for Knight. His survey thus revealed two employers willing to accept an application from a person in a wheelchair with Knight's vocational profile. One employer offered an opportunity for Knight to work at home and would allow him to move about consistent with his needs and restrictions. The pay range for the first job was $6.00 to $7.50 per hour plus commissions after training, and for the second, $8.00 per hour. These jobs in Robinson's opinion were both available to Knight and suitable considering Knight's education, age, physical limitations, functional limitations and work experience.

Neither job imposed any significant physical requirements. The first job,in terms of sitting, was hundred percent, but it allowed the employee to sit and stand periodically, as needed. The second job involved two week training at that company's location, after which, the employee worked at home, answering incoming calls from customers from around the country. The job required decent reading skills because the employee had to read a script.

Robinson determined that these positions met the qualifications and restrictions placed on Knight by his treating physicians and submitted his findings to Dr. Hooshmand who concluded that both jobs suited Knight "quite well" with one exception, "sitting one hundred percent of the time is harmful, if not more harmful than constantly moving around. He should frequently change position with resting intervals and moving intervals." In follow up with the two employers, Robinson determined that Knight would be able to sit and stand intermittently as needed.

DISCUSSION

Section 20 Presumption

Section 20(a) of the Act provides Claimant with a presumption that his condition is causally related to his employment if he shows that he suffered a harm and that employment conditions existed or a work accident occurred which could have caused, aggravated, or accelerated the condition. *See*, Merill v. Todd Pacific Shipyards Corporation., 25 BRBS 140 (1991), *aff'd*, 892 F.2d 173, 23 BRBS 12 (CRT) (2d Cir. 1989). As noted above, there is medical evidence in this record

which satisfies the above criteria. Virtually every physician who has evaluated Claimant's condition, whether viewed as RSD or CRPS or a combination of both, attribute it to the left knee injury he sustained on May 8, 1995 or the surgery performed on June 30, 1995, to repair that knee injury. In addition, the evidence is sufficient to invoke a Section 20(a) presumption that the condition has migrated to other parts of Knight's body and has involved skin rashes, vasospasms, immune disorders, memory loss, and other conditions related to his injury. (See, Reports by Drs. Hooshmand, J. Green, Fralicker, Ashchi, and testimony by Dr. Rowe).

Rebuttal

Upon invocation of the presumption, the burden of proof shifts to employer to rebut it with substantial countervailing evidence. Merill, 25 BRBS at 144. If the presumption is rebutted, all the evidence is weighed and a decision rendered based upon a review of the record considered as a whole. *See*, Del Vecchio v. Bowers, 196 U.S. 280 (1935). Claimant, however, always has the burden of establishing the nature and extent of the injury. *See*, U.S. Industries/Federal Sheet Metal, Inc., et al., v. Director, 455 U.S. 608, 615 (1982); Trask v. Lockheed Shipyard & Constr.Co., 17 BRBS 56, 59 (1980).

While the evidence fails to rebut the presumption that Claimant has CRPS related to his original injury or the subsequent left knee surgery, Employer has adduced substantial countervailing evidence which rebuts the presumption that Claimant's RSD or CRPS has migrated beyond his left lower extremity or involves brain, cardiac, immune system, or dermatological conditions. (See, reports and testimony by Drs. Koslowski, Hardy, Pulley, Eichberg, and Barsa). Since the presumption of migration of Claimant's conditions beyond the left lower extremity has been rebutted, the record as a whole must be evaluated to determine whether Claimant has sustained his burden of establishing the nature, extent, and etiology of conditions which effect him in areas other than the left lower extremity.

Claimant's Credibility

Because the Section 20(a) presumption has been triggered and, in part, rebutted, it is necessary to consider the record as a whole to determine the merits of the claim for relief Claimant seeks, and, in no small measure, the outcome depends on Claimant's credibility. I am mindful that several physicians have diagnosed RSD based upon objective manifestations including osteopenia or bone loss, left leg

atrophy, temperature differentials, changes in skin color, and hair growth pattern changes, and the results of clinical tests such as thermography and bone scan data. While Dr. Koslowski's test results provided data that were not entirely consistent with a diagnosis of RSD, the overwhelming weight of the medical evidence, supported by the opinions of Drs. Pulley, Rowe, Eichberg, and Barsa, Employer experts all, confirms the diagnosis of RSD or CRPS and its etiology is the May 8, 1995 injury or the surgery subsequently performed to repair it.

Nevertheless, while the diagnosis of RSD is predicated upon, and amply supported by, objective data, the nature and extent of the disability and the relief Knight claims he needs is grounded upon his subjective descriptions of the extent and degree of discomfort he endures and the disruption in his daily activities he claims to experience. The record shows that Knight's subjective complaints are more widespread, intense, and long-standing than most RSD patients experience, and medical reports in evidence reveal that his subjective symptoms constitute a key factor physicians rely upon in assessing his condition. Patient credibility is crucial in such circumstances.

I do not doubt that Knight experiences pain and discomfort as a result of his condition, and consideration of his credibility emanates from no lack compassion for his suffering; but for the reasons which follow, I am unable to credit fully his accounts of the degree of pain he experiences or the memory loss, concentration problems, and communication difficulties he describes. This is significant because these complaints, in turn, constitute the bases for much of the current treatment he receives and the lifestyle relief physicians, such as Drs. Hooshmand, Green and Fralicker, have prescribed for him.

Yet, the evidence in this record substantiates the concern of physicians who tended to place less reliance upon Claimant's subjective complaints. This, of course, is not an observation critical of doctors who fully trust him. Medical experts customarily and routinely rely upon their patients' description of symptoms and accounts of pain in formulating diagnoses and treatment plans. When a witness is not credible, however, the subjective complaints he filters through a physician or other health professionals who dutifully recount them in a medical report are entitled to no greater weight than a trier of fact might accord the patient's testimony at a hearing. Witness credibility, in all its forms, rests within the province of the trier of fact not the physician.

Subjective Memory, Concentration,
and Communication Problems

The degree of pain Claimant experiences is but one subjective element of his condition and I will address it in a moment. His reported memory, concentration, and communication problems are also largely subjective, and the record allows the veracity of these complaints to be tested fairly directly. Drs. Hooshmand, Green, and Fralicker all noted Knight's reported loss of concentration and memory and attributed it to his RSD. Dr. Green opined that the memory loss was possibly due to involvement of cerebral vessels with the CRPS or a reaction to medication.

Indeed, Knight reports that the problem is so severe that he can not concentrate while driving, can not recall what he read or remember errands he needs to run, recall why he moves from one room of his apartment to another, and forgets food on the stove or in the microwave creating a fire hazard. Attendant in-home care is therefore needed, he contends, to prepare his meals and take care of daily necessities of life he would forget to perform; "It's uneven, but a common thing that happens is I can read something and by the time I get to the bottom of the page, I can't remember what I've read." Tr. 401. Yet, Knight's testimony at the hearing revealed that, his subjective complaints to the contrary notwithstanding, he not only retains the capacity for intense concentration over long periods of time but is blessed with an impressive short-term and long-term memory.

The second day of hearing convened at 9:56 A.M. on June 12, 2002. After a few preliminary matters, Knight was called by his counsel, Tr. 370, and except for a few brief, routine recesses, he testified until the hearing recessed at 6:10 P.M. Tr. 626. On June 14, 2002, he was again called by his counsel to testify on rebuttal. Tr. 1094-1129. From the outset of his testimony, Knight was attentive, focused, extremely articulate, and provided detailed, finely nuanced explanations in response to probing questions. Indeed, he accurately detected ambiguities in counsel's inquires and sought appropriate clarifications. On both appearances as a witness, he testified without the use of notes and his presentation demonstrates, in its totality, and in specifics which I will illustrate by example in a moment, that his memory of fact details, technical medical and legal matters, events and communications with others both oral and written, chronological sequences, financial matters, physical circumstances and mental impressions he experienced years ago is objectively far keener, sharper, and more vivid than he subjectively describes it. Recognizing that

trial testimony is often aided by intensive pre-trial preparation and document review, the concentration and recall power necessary to produce the testimony reflected in this record remains quite remarkable especially in light of Claimant's assertion that "I can read something and by the time I get to the bottom of the page, I can't remember what I've read," Tr. 401, that he "...usually forgets a thought before he can write it down..," CX W, and "has trouble even remembering where he stopped or what he read...." CX.W. His testimony as a whole casts serious doubt upon the veracity of these assertions.

The record shows, for example, that Knight was referred to Genesis Pain Management Group in March of 1996. He testified from memory regarding this experience:

> Q. Casper, why did you not continue with the therapy at Genesis?
>
> A. Well when I went and asked my employer and ARM about that problem, they said that they were willing to authorize the treatment. And so I did make the appointment and keep it, as Ms. Davis said today, and there was some delay because of the, you know, back and forth with Joe Shaia, with my employer, but by the time it was scheduled and I showed up, you know, I went in because they claimed if I presented for that appointment and anything I did caused pain, they would tell the doctor it was okay, that if he felt it was appropriate that he could prescribe me pain medicine. So I presented. I tried to do everything Ms. Davis asked of me, you know, and then after the period of time, approximately a little bit under an hour, she said, I believe it's correct, I told her, you know, "This is more than I can tolerate, I've got to stop, you know, I'm sorry, but I don't think I can do this again without some relief provided by medication." And so she said, "Well, you know, you have to take that up with the doctors." I went back to the manager, asked if I could speak to the doctor about that, was not able to while I was there. So I phoned them, phoned Joe Shaia again and I believe even talked to the Department of Labor here

> downtown, the federal Department of Labor several times and even wrote them a note complaining that no one was willing to give me any pain medicine and I could not perform the therapy without it and so, no more appointments were made.

Now this testimony addresses events discussed not only by Ms. Davis earlier in the day, but details of conversations between Knight and Ms. Davis which occurred in 1996. He recalled the circumstances of his visit with her including the fact that it lasted a bit under an hour. Knight not only concentrated upon Davis's testimony but recalled it in the context of their meeting in 1996. Yet, this demonstration of his powers of recall was just the beginning.

On rebuttal, on June 14, 2002, Knight was asked by his counsel to comment on testimony received earlier at the hearing regarding the willingness of Genesis to allow a patient to take medication while in therapy. The names of the witnesses who so testified were not mentioned in the question posed to Knight nor were the underlying fact predicates upon which the question was based. Knight responded from memory with a degree of detail that was impossible to ignore:

> ...Dr. Wittmer, (who testified on May 24, 2002, the first day of the hearing) I believe mentioned that and I believe Ms. Davis today mentioned something in reference to that. And Dr. Vincenty seemed to think that I was treating with Dr. Koslowski at the same time and I was not, you know. He's mistaken on that. I understand it's hard for him to remember that detail. I don't fault him for that. (Knight here was recalling the period in 1996 when he was seen by Dr. Vincenty and Dr. Koslowski). I was not treating with both of them at the same time, nor was I treating with either of them or another physician outside of the Genesis group that are named on the report, getting medication from them.
>
> So that was my complaint to Ms. Davis, to Dr. Wittmer and to Dr. Jawed Hussain who was the physiatrist, was that although when they examined me and four weeks later produced that report, I had been without medication for several months, you know, unless I went to the grocery store and bought over the counter strength and

took that and guessing at what I should take or how much and had no treating doctor, you know, willing to prescribe anything and even though I told them that and they said, "Well, Tegretol might be worth trying," in their report -- I remember that being stated -- no one would actually write me a prescription for any medication, including Tegretol because they told me that no treatment had been authorized and recollecting a discussion back in the spring of 1996 Joe Shaia (the claims adjuster) told me the same thing."

Q. Who told you?

A. Dr. Wittmer, Dr. Hussain and Ms. Davis. Now of course, she doesn't prescribe, so I know that was just, you know, just knowledge of something. So I'm not faulting her. But neither Dr. Wittmer, nor Dr. Hussain -- well, I guess Dr. Wittmer as a psychologist probably can't prescribe it. Tr. 1108-1109.

At the hearing, the employer suggested that Knight had the physical capacity to perform such sedentary jobs as telephone solicitor. The jobs were not suitable for other reasons, but in describing the effects of his RSD, Knight further testified that he "has difficulty putting thoughts together and communicating effectively," CX. DDD at Tr. 98-99, experiences diminished mental ability which leaves him "unable to compose clear thoughts and speech," and that throat spasms and hoarseness prevent him from speaking "for days at a time," and often when he speaks "no sound occurs." CX. W. See, Tr. 49-52; Tr. 96. See also, CX. X pg. 8. Obviously, a condition which causes such communications problems would preclude one from performing the duties of a telephone solicitor, but the record reveals that these subjective complaints are either flatly untrue or deceptively exaggerated. Knight not only provided clear, cogent, and well-considered testimony, he testified for hours in a voice unimpeded by mechanical interference or failure.

While Claimant's subjective complaints of diminished mental faculties naturally evoke a compassionate response, the claimed impairment provides a striking contrast with the substance of his testimony. Knight, for example, addressed questions regarding his medications adduced by his counsel at the hearing

on June 14, 2002. The degree of detail, sequencing of physicians, medications, and technical names which flowed easily, without halting or hesitation, in an articulate organized description, without notes, belie the notion that Knight is an individual with serious memory loss and impaired ability to compose clear thoughts or speech due to mental residuals of a work-related injury. Knight explained:

> Each time I see any of the MD's, I would not discuss it with my therapist, since they don't prescribe anything, but each time I see either Dr. Ashchi, my cardiologist who he generally prescribes the Nitrostat or the nitro patch and the Norvasc, or Dr. Green who is likely the one who usually prescribes my Mycalcin, and the Zanoflex and potentially if I can't get in to see Dr. Ashchi because he's too busy or something, he might give me a refill until I can get back to see Dr. Ashchi, or the same thing with the medication that perhaps Dr. Hooshmand might prescribe, since Dr. Green is my primary, he reviews all the medication of each doctor's prescription for me on my case and each time I go to see any of them, including Dr. Hooshmand, they always discuss what I am presently taking, what the dosage is, if I'm having any negative effects or I guess you could call them side effects, and then they determine whether there should be any changes or not and aside from my having trouble affording them and being able to refill some of the ones that are not compounded, I don't believe there's been any major changes in approximately the last year, except I have had to stretch out the dosage a little bit because I have not been able to pay for all of them and of course, it's already known some of these expenses were controverted or everything was controverted for a period of time. I'm severely behind financially.
>
> *****
>
> Q Mr. Knight, with regards to your use of medications, have you discussed the use of medications, including narcotics with your doctors as far as the effects?

> A Yes, I have. It was my understanding that -- from Dr. Hooshmand and Dr. Green that the Buprenex, as Dr. Vincenty, I believe stated here today, has a safety factor to it. It helps reduce some of those negative effects, like the problems of slowing down your respiration which put me in the hospital when I tried morphine back in the summer of '97, I believe, when that happened. I had tried some morphine, which is cheaper and more commonly used, but I had a severe reaction for it and had to call for an ambulance, was taken to the hospital, spent a week in St. Luke's Hospital from those side effects.

In assessing Knight's testimony that he is unable to remember, to organize, and communicate ideas due to his RSD, testimony regarding his interactions with Rick Robinson, a Vocational Rehabilitation Specialist, is illustrative. Reflecting on Robinson's earlier testimony, Knight recalled:

> As he stated, he had apparently sent a few letters, but for some reason, I did not receive them and then one was taped to my door and I don't always go out on a daily basis, which was found a couple days after. I think it was actually taped there, but nonetheless, I tried to phone him. He was not in his office and so when I was out for other reasons, I had my driver from Mr. Diaz's company, Kingdom Services, take me to his office, I believe on two occasions, try and meet with him and find out what exactly they wanted because my understanding was none of my doctors had released me for work, so I didn't understand what was going on or what exactly I was supposed to be doing and when I went there, there was no one there, except a temporary employee. She was the only one there and the only thing we could get by way of information were two business cards, one for, I believe Mr. Robinson's partner, Jerry Alpert, and I think a female therapist, but no one was in the building except for the receptionist, and she could not answer any questions."

Recalling a visit to Robinson's office, Knight testified that he:

> ... happened to notice at the time that on the sign appeared the name of my Employer, one of the Employer's physicians that worked for Atlantic Marine." ....Associated Rehab Clinic was claiming, I believe in the communication that was sent to me, the letter, that I was supposed to be recommended for some sort of independent evaluation or something for vocational training, something like that, and I believe I had tried to ask Mr. Shaia what exactly, what it was and he said, you know, "Well, I can't explain that to you; you'll have to go talk to them and they will explain it to you." I said, "Well, you know, it costs me money to go see them, you know, can't you tell me, you know, why you want me to go there." "Yes, you know, I'll let them explain the details." "But can't you tell me why you're trying to send me there," and he would not and when I saw the name of William Knibbs on the sign at Associated Rehab on the street sign and on both sides of the building and there were three or four other businesses there that all use the same address, the same phone number and later in time, found out, you know, owned by the same people, as he mentioned today. They now have a new name. And it just seemed kind of peculiar. It was more questions, that there was more legal than medical reason for this visit."

Yet, his ability to concentrate on and remember fine detail is perhaps best reflected in the concerns Knight expressed about Robinson's credentials.

> Well, I was -- I was concerned that Dr. Knibbs might be trying to influence what he (Robinson) would say and then the letter he sent to me had one, I think one set of initials next to his name, you know, like a credential abbreviation, but the letters he sent to my doctors that he referenced today, he sent them some questionnaires, he had like six abbreviations of credentials, including one that said, I think it's LMHC, which is supposed to stand for licensed

> mental health counselor and that was a concern because I didn't really agree with that type of counsel and I wasn't sure if that's what I was being sent there for because they had misrepresented to me a couple of times, you know, the purpose of things and I had participated in the exam with Genesis because I felt I was obligated to do that by law from speaking to the Department of Labor. You know, they said, "You have to submit for an exam." I said, "Okay, I'll do that." They said, "If your beliefs disagree with that, you don't have to submit to the treatment, you know, unless it's absolutely indicated by your other physicians, but you do have to present for the examination and cooperate," and so I did that. But I wanted to understand why I was going there and I thought Mr. Robinson by giving me one set of credentials, you know, but giving every single person, other than me, the full list of those credentials seemed a little dishonest and strange, that maybe he was being influenced about what he should do.

Nor are the foregoing examples isolated instances extracted episodically from the record. To the contrary, they are merely illustrative of the impressive memory and recollection of spoken and written material, and the ability to communicate Knight demonstrated over many hours of testimony. See, e.g.: Tr. 390-397, Tr. 417-418; Tr. 533-535; (financial matters): Tr. 402-03 (circumstances of light duty work in 1995); Tr. 421-424; 428-29; Tr. 502; Tr. 505-507; Tr. 553-559; Tr. 1104 (legal matters); Tr. 463-65; Tr. 468-69; Tr. 475-477; Tr. 518-519; Tr. 584-85,(medical matters); Tr. 489-494; Tr. 592; Tr. 1103 (long-term memory); Tr. 590; Tr. 604 (recent matters); Tr. 1095-96 (written material).[11] On occasion, he could not recall a specific fact or event and so stated, but instances in which this occurred reflect no greater memory failure on his part than witnesses with no alleged memory

[11] The record, time and again, demonstrates Claimant's impressive long-term and short-term memory. For example, he vividly recalled the light duty work he performed in 1995 following his injury, including the paper work his supervisor assigned to him, the reduction in his hours to 40 per week, the "hazardous environment," and even such minutia as the "tile floor in the restroom, and the debris on the floor." He recalled the order of scheduling of various IME's "a couple by Dr. Tandron, and by Dr. Rowe, and then Dr. Hardy and Dr. Koslowski." Tr. 404. He recalled a February 6, 2001, bill for $375, including what it was for, who prescribed it, and who approved it, Tr. 404-05, and he recalled a CT scan and two MRI's, including the month one MRI was administered, and that it was authorized "before my case was controverted." Tr. 405.

or concentration problems routinely experience in similar situations. Indeed, Claimant's appearance in more than seven hours of testimony over two days of hearings revealed that he was able, as the transcript amply confirms, to concentrate on complex proceedings, recall events and testimony of others in exquisite detail, articulately express his views, organize and communicate complex ideas, and carefully construct and articulate his arguments, unimpeded by his residuals or his medications.

Subjective Pain Complaints

At the hearing, at deposition, in written statements in evidence, and consistently over many years in reports to Drs. Hooshmand, Hashmi, Green, and Fralicker, Knight has described his pain as constant and always severe at a level of 7-9 on a scale from 1 to 10. Indeed, during scores of visits to his physicians, he has rarely reported pain levels below level seven. Yet, over the years, various other physicians have had occasion, based on their experience with Claimant's condition, either to note inconsistencies between their examination findings and Claimant's complaints or directly question the veracity of his complaints. Based upon my observation of the appearance and demeanor of Claimant at the hearing and a careful review of his testimony, I am persuaded that concerns about his probity are not devoid of substance.

Dr. Vincenty, for example, noted that Knight, while not a malingerer, was "manipulative," and others such as Drs. Hardy, Koslowski, Eichberg, and Barsa have found it difficult to reconcile his subjective complaints with the objective medical evidence. Thus, Dr. Koslowski reported that Knight's pinprick response "made no sense." Dr. Wittmer and Ms. Davis observed that Knight exhibited minimal pain behavior, and more recently, Dr. Eichberg reported a lack or correlation between Knight's standing and sitting left leg range of motion results and questioned the veracity of Knight's response on a patient history questionnaire describing his pain as "Whole body, plus, plus." Dr. Eichberg explained that he was unfamiliar with any condition that causes whole body pain, and even Dr. Hooshmand seemed to concur when he opined that it is "impossible" to get whole

body pain.[12] Dr. Pulley believed that reports of pain in areas of the body other than the left leg were likely not due to RSD or CRPS.

Others such as Dr. Fralicker and Dr. Hooshmand, who fully credit Knight's pain complaints, report that his pain requires him to be in constant motion seeking a comfortable position. Dr. Fralicker, for example, diagnosed Knight at MMI and rated him as permanently and totally disabled, noting that he "cannot sit in one position for more than ten or fifteen minutes" and "has very poor concentration due to his pain level as well as weakness." It may here be recalled that Dr. Hooshmand vetoed two jobs as unsuitable for Knight because they involved 100% sitting. Dr. Hooshmand warned that Knight's condition "is aggravated by too much rest or too much activity as well as stress." CX. TT. Indeed, Dr. Hooshmand commented on May 20, 2002 that any job that required sitting 100% of the time could do more harm than constantly moving around. He advised that Knight should frequently change position with resting intervals and moving intervals alternated, CX. CCC pg. 6, "He should be in perpetual motion, finding a position that does not cause pain." CX. DDD at Tr. 111. "The moment you spare the patient from surgery, and ice and casts and immobilization and wheelchairs they're going to have success." Tr. 69. Dr. Hooshmand further advised that RSD patients must move around a lot. CX. DDD at Tr. 156. Considering the description of pain Claimant entered into this record, (See, pgs. 3-5 supra), it is difficult to imagine that he would not do everything in his power to, as Dr. Hooshmand explained, remain "in perpetual motion, finding a position that does not cause pain."

Now, I understand that Drs. Hooshmand and Fralicker were not describing vigorous movement, but rather constant, and guarded adjustments; yet, no aspect of Knight's appearance at four days of hearing confirmed in any respect the pain behavior Drs. Hooshmand and Fralicker report that Claimant's subjective symptoms impel him to exhibit. The hearing on May 24, 2002, convened at 8:59 A.M. and continued with few interruptions until it adjourned at 5:05 P.M. Knight was present from the beginning, having been brought into the courtroom in a wheelchair; and, although he was free to stand, stretch, or move about at his discretion throughout the day, he elected to remain seated, virtually motionless, during the entire time proceedings were in session. It may thus be recalled that Dr. Hooshmand rejected a

[12] While Knight initially presented objective diagnostic factors for RSD, such as hair pattern changes, and temperature and skin color differentials, the severity of his pain and its effects are based upon his subjective descriptions.

job as unsuitable for Knight because he believed Knight could not and should not remain seated that long.

On June 12, 2002, the second day of hearing, Knight's counsel called him as witness. That hearing convened at 9:56 A.M. and adjourned at 6:10 P.M., and Knight testified virtually the entire time hearings were in progress. Again, he was free to stand, stretch, adjust his position, or move about, and he and his counsel were free at anytime to request a recess, routinely and liberally granted in disability cases to accommodate a claimant's needs. Yet, despite his testimony on June 12 that he was in pain because he sat through the entire first day of the hearing, Tr. 454, Knight again remained seated on a pad he had placed on the witness chair throughout the entire time hearings were in session without constant movement or adjustments; and, despite the type of behavior Drs. Hooshmand and Fralicker advise should be expected, Knight, only once, about mid-afternoon on June 12, expressed any need to stand and stretch. Tr. 528. His stamina, in this regard, in fact exceeded the capacities exhibited by at least one attorney in attendance at the hearing.

Thus, confirming the reports of Dr. Wittmer, Ms. Davis, and Dr. Eichberg, and eschewing any form of sit and squirm jurisprudence or index of traits applied in isolation, it must nevertheless be observed that during the entire time he testified, Claimant exhibited no discomfort. His behavior changed markedly, however, when it became apparent to him and his counsel, near the end of the second day of hearing, that an assessment of his appearance and demeanor was an integral part of the overall hearing process.[13] After that, Knight exhibited behavior reminiscent of Dr. Vincenty's observation that Claimant's actions, at times, are designed to "manipulate" the system.

He no longer sat through the proceedings but rather sought permission to place a body-length cushion on a bench in the courtroom, where, lying down, wrapped in a blanket, head propped up on the arm of the bench, he observed the proceedings for the next two days only occasionally sitting up to consult with his

[13] As noted above, his counsel at the end of the day on June 12, despite a day's worth of testimony demonstrating the contrary, led Knight to testify that pain distracted him as he testified in the courtroom. Upon the declaration and question of his counsel; ".... this has been medically confirmed that 'pain is present to such an extent as to be distracting to adequate performance of daily activities of work. Has your pain been distracting to you today in this courtroom?'" Knight responded; "Yes." Tr. 622-23. To further emphasize the point that his client's actions in the courtroom may have been inconsistent with his subjective memory and communication complaints, counsel revisited the issue at end of the hearing on June 14, 2002 when he expressed concern that Rick Robinson, the vocational expert who observed Knight's appearance, commented that Knight demonstrated in testimony the ability to engage in clear, logical, cognitive processing of information and abstract ideas.

attorneys until he was called again to testify on rebuttal. Once he resumed the witness stand on rebuttal, however, the sedentary, listless, nearly motionless demeanor he exhibited while lying on the bench again changed. Apparently absorbed in the proceedings and diverted from the conscious effort to exaggerate his condition, Knight sat still but upright, alert, energized, and well prepared to address the testimony of other witnesses with whom he disagreed, while again exhibiting no outward signs of distress or pain induced distraction.

I am, of course, mindful of counsel's admonition that he would deem it unfair to "hold against" Claimant relevant observations regarding his attendance in court and his appearance as a witness, but such observations are clearly pertinent to important issues raised in this proceeding. (*See*, U.S. v. Schipani, 293 F. Supp. 156, 163 (E.D. N.Y. 1968, aff'd 414 F.2d 1262 (2d Cir. 1969). Knight's doctors report that his pain levels trigger constant, observable, physical movement. It is, therefore, significant when his actual voluntary behavior is precisely the opposite of the reaction they expect.

Knight thus elected to remain as sedentary as possible, notwithstanding Dr. Hooshmand's advise that he should "be in perpetual motion" and that a "sitting" job would "aggravate" his condition, and Dr. Fralicker's report that pain causes constant motion as he seeks a comfortable position. Claimant, however, is capable of remaining comfortably sedentary far longer than Dr. Hooshmand or Dr. Fralicker might imagine.[14]

For all of the foregoing reasons, I find Claimant's testimony that he constantly experiences pain at level seven or above over most of his body is exaggerated to a significant degree and lacks credibility. Now, this is not to say that Claimant is pain free or that he may not, at times, experience significant discomfort, but he has exhibited a proclivity to exaggerate his subjective mental and physical symptoms and this diminishes the reliability of a medical evaluation which relies upon his subjective complaints.

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[14] Upon reviewing the documentary evidence post-hearing, I noticed that Dr. Hooshmand commented on Knight's painful reaction to being required to sit for extended periods of time during his pre-trial deposition. This deposition testimony by Dr. Hooshmand was not, however, brought to my attention at the hearing. Thus, the duration of each period of claimant's testimony at the hearing, and his ability to stand, stretch, or move about was left to Claimant and his counsel. As the record demonstrates, however, Claimant's ability to withstand the rigors of trial exceeded, in some instances, the endurance of counsel.

The record further shows that Drs. Hooshmand, Hashmi, Green, and Fralicker assessed the nature and extent of Claimant's condition, in significant part, on his subjective reports, and their opinions must be accorded diminished weight accordingly. Even with objective findings which support the diagnosis of RSD, I find and conclude that when a physician relies upon Knight's description of his pain as constant at level 7 to 9, the physician is likely to be misled in respect to the nature, extent, and seriousness of the symptoms the objective problem may actually trigger. A physician may, for example, be more willing to opine that a patient cannot perform sedentary work and prescribe the installation of an in-home jacuzzi type spa in a new larger residence if the patient reports constant, assiduous, severe pain and dangerous memory loss than if the patient demonstrates, as Knight has, that he is able to sit for long periods of time without outward signs of discomfort let alone serious pain, and retains a memory capacity and ability to concentrate and communicate that many doctors and attorneys might find difficult to match.

Based upon his reported complaints, his testimony, demeanor, and appearance at the hearing, I find that Knight has a tendency to embellish and exaggerate his subjective symptoms, and I believe he did so with his doctors and at the hearing. Accordingly, I find and conclude that Claimant, as a witness, lacks credibility.

Total Disability

The record shows that Knight has been receiving compensation for total disability since 1995 with interruptions which I shall address in a moment, and such compensation should continue. Employer does not contend that he can return to his job as a shipfitter, but it did attempt to establish that he has a residual wage earning capacity. Citing two jobs identified by Rick Robinson, it argued that suitable jobs are available for someone with Knight's limitations, and he should be earning an income.[15] It acknowledges that Dr. Hooshmand vetoed these jobs as too sedentary, but Robinson confirmed with the prospective employers that the positions would allow Claimant to engage in the physical activity Dr. Hooshmand considered necessary. Nevertheless, the jobs remain unsuitable at the present time.

[15] Although the Employer, at the outset of the hearing, argued that Knight is temporarily, totally disabled, (See, Tr. 233), and later contended that he is not totally disabled, (See, Tr. 451-452), it came full circle in closing argument at the hearing stating; "the Employer is willing to continue paying Mr. Knight temporary total disability benefits, as we have all along, save for that period of controversion and that temporary total disability benefits continue to be paid to Mr. Knight...."

The Employer called Dr. Barsa as an expert witness. In the course of his testimony he was asked to consider Knight's current wage earning capacity. In his opinion, Knight is capable of sedentary work on a part-time basis, but "[I]f you ask me would I send him back to work, the answer is 'no'... I don't recommend work until the drug problem has been resolved."

After observing the testimony of Dr. Barsa at the hearing, Robinson acknowledged that Claimant's drug use raised a question about his employability at present, and he would have discussed it with potential employers had it been brought to his attention. Understandably, however, drug use was not a factor which concerned Robinson because, as he testified, Knight's medications were not a concern to Dr. Hooshmand when he assessed the jobs Robinson located. See also, EX 41. Nevertheless, considering the testimony of Dr. Barsa, it would be difficult to conclude on this record that Employer has satisfied its burden of establishing that Knight presently retains a residual wage earning capacity, and I, accordingly, conclude that he is at present totally disabled.

Permanency

While I have concluded that Knight is presently unable to engage in gainful work, I find that he has failed to establish that his condition is permanent. In view of the unreliability of his subjective accounts of the nature and extent of his impairments and the degree of discomfort he experiences as a result of his RSD or CRPS, I have concluded that the medical assessments of Claimant's response to treatment and the permanency of his condition are also unreliable.

Because Claimant's reports of his subjective symptoms, in ever increasing severity and deterioration over the past five years, are unreliable, reports by physicians that he reached a plateau in his medical progress cannot be fully credited, and case law applying the rules for determining permanency are not applicable. None of the cases address the problem of establishing medical permanency ratings predicated upon unreliable subjective complaints. Ecklev v. Fibrex & Shipping Co., 21 BRBS 120, 122-23 (1988). Phillips v. Marine Concrete Structures, 21 BRBS 233, 235 (1988); Track v. Lockheed Shipbuilding & Constr. Co, 17 BRBS 56, 60 (1985); Drake v. General Dynamics Corp., 11 BR.BS 288, 290 n.2 (1979); Watson v. Gulf Stevedore Corp., 400 F.2d 649, 654 (5th Cir. 1968), cert. denied, 394 U.S. 976 (1969);. *See also*, Crum v. General Adjustment Bureau, 738 F.2d 474, 480 (D.C. Cir. 1984); Air America. Inc. v. Director, 597 F.2d 773, 781-82 (1st Cir. 1979); Care v. Washington Metro. Area Transit Auth., 21 BRBS 248, 251 (1988).

Claimant's credibility here is sufficiently impeached to raise serious doubts about the medical reports of permanency and degree of impairment that rely upon his subjective pain, memory, and concentration complaints. Under such circumstances, Knight's burden of establishing the permanency of his total disability has not been satisfied.[16]

Relief

A number of issues related to questions of relief contested at the outset of the hearing are no longer challenged. Employer has, for example, agreed in its post-hearing brief to pay out-of-pocket expense claims submitted by Knight which were denied during the period his benefits were suspended, if "the court orders that Employer was not entitled to suspend benefits during that period...." That condition precedent, as discussed below is resolved in Claimant's favor, and accordingly, the medical expense claims denied during the period Knight's benefits were suspended will be reimbursed with interest.[17]

Unjustified Suspension of Benefits

The Employer initially argued that it suspended Knight's benefits from September 11, 2001, thorough January 4, 2002, because he refused cooperate with its efforts to schedule an IME with Dr. Michael Stanton-Hicks at the Cleveland Clinic.[18] Claimant, however, denies that the employer ever scheduled an IME with Dr. Stanton-Hicks or that he ever refused to attend an IME with Dr. Stanton-Hicks. The record shows that both parties, from time to time, have attempted to access the expertise available at the Cleveland Clinic but each rebuffed the other when the opposition found merit in the journey.

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[16] Under such circumstances, the Employer's Section 8(f) defense need not be considered.

[17] Claims totaling $118,000 filed by Neurological Associates were settled during the course of the hearing. Charges totaling $78,000 by Southeastern Neuroscience Associates/ Dr. Green were contested by the Employer, and the provider failed to file a claim for reimbursement. Because no claim was filed, the propriety of Southeastern's bills were not addressed in this proceeding. Similarly, attorney's fees charged by Claimant's former counsel for proceedings before Judge Teitler were referred to Judge Teitler for consideration.

[18] In its post-hearing brief, Employer attempted to expand the grounds which support its suspension to include a failure to cooperate with discovery requests and a refusal to sign a medical release form authorizing an evaluation by Dr. Stanton-Hicks.

Thus, Dr. Jacob Green, on July 11, 1997, first suggested that Knight might benefit from a consultation with Dr. Stanton-Hicks. CX. M. Later, on September 3, 1997, he again anticipated that Knight "may need later to see Michael Stanton-Hicks...," EX. 1 at P.72, and on July 23, 1998, he affirmatively recommended that Knight be authorized to see Dr. Stanton-Hicks who he described as "the greatest expert in this disorder." Dr. Green thought it in Claimant's best interest that he see Dr. Stanton-Hicks. CX. DD; See also Tr. 496. The Employer, however, disagreed. In its LS-207 dated September 10, 1998, Employer advised; "Issue of a referral to Dr. Stanton-Hicks in Cleveland, Ohio is controverted."

Based upon the Employer's controversion of this, and other issues, the matter was forwarded for hearing and the case was assigned to Judge Teitler. Following a brief hearing before Judge Teitler, the parties entered into settlement negotiations in February, 2000, and drafted a proposed agreement which included a provision imposing upon Knight full responsibility for any subsequent visit with Dr. Stanton-Hicks. CX. KKK. Knight found the proposed settlement unacceptable, but the particular provision relating to Dr. Stanton-Hicks is relevant here to the extent that it places in context the events leading up to the controversy which subsequently developed when the employer changed its opinion about the value of Dr. Stanton-Hick's advise and became the proponent of a visit to Cleveland.

By the summer of 2001, the Employer was insisting on a consultation with Dr. Stanton-Hicks, and it advised Knight that it was in the process of scheduling him for an evaluation. In an LS-207, filed on September 5, 2001, "...employer requests claimant to present for evaluation with Dr. Micheal Stanton-Hicks Cleveland Clinic." Knight testified that he wanted the appointment, Tr. 387, but the arrangements were never made, because, as he understood it, the Employer demanded that he pay for the trip to Cleveland and other costs of the visit. Tr. 388. Knight denied that he ever refused to attend the IME, Tr. 416; Tr. 591, but insisted he thought the Employer expected him to pay for it, Tr. 498, and I find that his understanding is not unreasonable in this regard.

The record shows that when Knight initially sought authorization to visit the Cleveland Clinic, the Employer objected and subsequently insisted that he pay for the visit. When the Employer finally decided that a visit to the Cleveland Clinic might be a good idea, it advised Knight in August of 2001 that it was scheduling him for an evaluation, but it apparently failed to explain that the Employer, not

Knight, would pay all costs associated with the trip. It merely requested that he call to discuss travel arrangements. At the time, Knight was not represented by counsel, and, based upon the Employer's prior demands, he reasonably concluded that the financial burden of the trip rested with him. The Employer certainly did not specifically advise him otherwise.

Nevertheless, on September 20, 2001, Employer completed an LS-207 controverting compensation allegedly due to Knight's "refusal to cooperate with management of care-will not respond to request for scheduling evaluation with Dr. Michael Stanton-Hicks." CX. QQ.[19] The next day, Employer's counsel wrote to Knight noting that they had unsuccessfully attempted to contact him and advising him that they had, "tentatively scheduled an Independent Medical Evaluation with Dr. Stanton-Hicks, at the Cleveland Clinic Foundation, in Cleveland, Ohio, for sometime during the first two weeks of November. Dr. Stanton-Hicks is out of the office for a few weeks, therefore, the exact date cannot be set at this time. We will keep you informed of the exact date once it is definitely scheduled." The letter to Knight failed to mention that an agreement between the Employer and the Cleveland Clinic required Knight to sign a medical authorization before the Cleveland Clinic would conduct the requested IME. CX. QQ. Notwithstanding this failure on the part of the employer, on the same day it advised Knight that it was tentatively scheduling the IME, it advised OWCP that Knight failed to sign the authorization submitted to him in response to an agreement between the Employer and the Cleveland Clinic, and this, in the Employer's view, constituted a failure to cooperate with the scheduling of the IME by the Cleveland Clinic. CX. QQ. Faced with this stepped up activity by the Employer's counsel, Knight again sought legal assistance.

On September 29, 2001, Claimant's new counsel contacted the Employer, and advised: "While you are certainly entitled to an IME, you request Claimant to present for examination by a physician Dr. Michael Stanton-Hicks, Cleveland Clinic. You do not indicate a location...." Thereafter, unlike the employer in Malone v. International Terminals, 29 BRBS 109(1995), Atlantic Marine no longer

[19] Employer in its post-hearing brief contends that an LS-207 dated September 5, 2001 and filed September 11, 2001, was predicated on "Mr. Knight's refusal to cooperate with regards to the evaluation by Dr. Stanton-Hicks. Br. At 15. The record shows that the Employer filed two LS-207 forms on September 11, 2001. See EX. 1, pp. 7-9. The attachment to one of LS-207's, lists four specific items of controversion. The Employer, contrary to the argument in its brief, did not controvert Claimant's failure to cooperate regarding an IME with Dr. Stanton-Hicks. As of September 5, 2001, the Employer was merely "[requesting] claimant to present for evaluation with Dr. Michael Stanton-Hicks, Cleveland Clinic." EX. 1, P. 8. The two LS-207' filed on September 11, 2001 did not otherwise allege a failure to cooperate with respect to that requested IME.

pursued Claimant's attendance at an IME by Dr. Stanton-Hicks, but rather sought to compel him to undergo an FCE and an IME performed by other physicians in Tampa, Florida.

The record thus fails to support Employer's contention that Knight's benefits were suspended based upon his failure to cooperate with an IME by Dr. Stanton-Hicks or that Knight, in fact, unreasonably refused to cooperate with the Employer in scheduling the IME. The Employer prepared its controversion and suspended benefits on September 20, 2001, the day before it wrote to Knight advising him that it tentatively scheduled the IME for sometime during the first two weeks of November, 2001. Employer, moreover, has failed to establish that Knight unreasonably concluded that the Employer expected him to pay for the IME it wanted or that he was aware of the link between the medical authorization and a specific IME at the Cleveland Clinic. Employer further failed to establish that it advised Knight of an actual date for the examination or that the Employer ever advised him of the final arrangements for the IME. To the contrary, when it finally sought to compel his attendance at an examination, the employer elected an alternative course of action.

For all of the foregoing reasons, I conclude that the alleged failure to cooperate with regard to an IME by Dr. Stanton-Hicks was not a sufficient basis to warrant a denial of benefits for the period September 20, 2001 through January 4, 2002. These benefits will, accordingly be restored.

Expenses For Travel to Tampa

As mentioned above, the Employer elected to abandon its effort to require Claimant to attend an IME in Cleveland and decided instead to seek an IME and FCE by Drs. Eichberg and Barsa in Tampa. Although Claimant was routinely visiting Dr. Hooshmand in Vero Beach, at a greater distance from his home than Tampa, he objected that Tampa was too far away and cited the concerns of Dr. Green that he would need pain treatment before and after any such travel.

A lengthy conference call was convened to address all of Claimant's concerns about the scheduled evaluation in Tampa, including the concerns then expressed by Dr. Green that Knight receive appropriate pain treatment both before and after the trip. Claimant's needs as described by Dr. Green were considered and accommodated, and he was, by order dated April 25, 2002, required to submit to an

evaluation in Tampa. The same order required the Employer to provide transportation, accommodations, and see to all his medical needs in preparation for that visit. The Employer has since declined to pay for certain of these expenses and Claimant seeks an order requiring it to reimburse him.

The record shows that, despite the order requiring the Employer to make and provide all arrangements for the trip, Knight elected to make his own arrangements. He also obtained a note from Dr. Green, dated May 1, 2002, in which Dr. Green stated a new objection to an FCE which was never raised during the April conference call. Dr. Green, apparently with knowledge that his concern about travel had been accommodated and that an FCE was ordered, shifted his objection to the FCE. He now objected to the FCE itself describing it as "dangerous" and "not prescribed." The Employer, however, was not advised of this new development, and Claimant, then represented by experienced counsel, did not seek a protective order based on this new information. Instead, Claimant presented this note to the doctors in Tampa.

Upon receipt of this note from Dr. Green, the Dr. Eichberg, who was prepared to perform the FCE, reasonably interpreted the note as a prescription from the treating physician that the FCE should not be performed. While Dr. Eichberg disagreed with Dr. Green about the risks of an FCE, he was not inclined, as he testified, to countermand the wishes of the treating physician. Accordingly, the FCE was not performed.[20]

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[20] Claimant's counsel at the hearing argued that Dr. Green did not actually recommend that the FCE not be performed and that this was merely an interpretation of his opinion by Dr. Eichberg. Having considered his note, however, I concluded that Dr. Eichberg's interpretation was reasonable, but in light of counsel's suggestion that Dr. Green did not oppose a limited FCE, Claimant was directed to re-contacted him for clarification of his position. The parties were further advised that I would be inclined to permit the Employer to schedule an FCE post-hearing after Dr. Green reported back. Subsequently when the Employer failed to re-schedule an FCE after Dr. Green commented post-hearing, a briefing schedule was established. The Employer then complained that it had previously requested, but was unfairly denied, a conference call to discuss the FCE limitations Dr. Green imposed. It appears that Employer buried its request for a conference call in the second paragraph of a letter addressed not to the court but to opposing counsel, and its request was not noticed until, during a subsequent conference convened for another purpose, counsel advised where he had made his request. Counsel argued that he had requested and received permission to file his comments to opposing counsel regarding Dr. Green's FCE limitations, and, therefore, the Employer's request for conference call, included in his letter to opposing counsel was properly submitted.

The Employer's objection that it was unfair not to grant it the conference call it requested, while e conference calls Claimant requested were granted, is without merit. While Employer was free to file a copy of its correspondence addressed to opposing counsel, and parties often do file letters of that type, such correspondence is

Under these circumstances, I conclude that Knight is not entitled fully to recoup expenses which he voluntarily elected to incur for this visit to Tampa. When new facts surfaced which fundamentally changed the grounds upon which he objected to the FCE he had been ordered to undergo, Knight was obliged either to disclose them in a timely manner to the Employer or seek a protective order. He elected instead to spring them on the doctors on the day of the FCE, and the physicians in Tampa acted reasonably in light of the information they were given. As a result, they reasonably performed the IME and deferred the FCE, and thus fulfilled only half of the objectives the slated trip to Tampa was expected to achieve.

As such, Claimant did not act reasonably and in good faith when he failed to provide timely notification to the Employer that he had obtained a new document from his treating physician which raised new objections to the FCE. This effectively precluded Employer from obtaining one of the two evaluations the April 25 order permitted it to obtain and from timely deciding whether the trip to Tampa was still worthwhile if only the IME could be performed. Accordingly, I find and conclude that Knight is entitled to recover only one half of his documented expenses for the trip to Tampa.

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not sufficient notice that a party is seeking specific action from the trier of fact. Thus, the applicable rules set forth at 29 C.F.R. §§ 18.3(e) and 18.6(a) provide that any application for an order or any request shall be made by motion with a proper caption which includes, inter alia, a designation of the type of pleading filed. These requirements are not hyper-technical. They are necessary to alert not only docket personnel but the presiding ALJ that a filing requires a proper response in due course. Indeed, Claimant's requests were addressed to the court and requested action directly. The Employer's request was addressed to Claimant's counsel, was otherwise buried in the second paragraph, and complied neither with the rule nor provide adequate notice. By the time it surfaced, the briefing schedule had been established and further proceedings were deemed dilatory.

In similar fashion, the Employer, months after the hearing, requested a discovery subpoena for records of a vein clinic Claimant visited for treatment. Employer noted that it first learned of the treatment involving the subject matter of the subpoena at the hearing. While Claimant's treatment at the vein clinic was discussed at the hearing, the Employer provided no explanation for waiting more than two months, and well after the briefing schedule had issued before pursuing its post-hearing discovery. Under such circumstances, the Employer's request was untimely and dilatory and the requested subpoena accordingly was not provided.

Covered Medical Expenses Incurred
By Claimant but not Paid

Although the record is not entirely clear with respect to reimbursements Employer has provided, I find that Knight is entitled to coverage for the following items: wheelchair pillow; a flu shot; prescribed medications; transportation for visits to Neurological Associates and Southeastern Neuroscience; and hand and shoulder treatments which this record shows were related to his use of crutches. In addition, although Employer adduced evidence sufficient to rebut the presumption that Knight's symptoms of vasospasms were related to his left knee injury, the record as a whole is sufficient to establish Knight's claim for coverage of this condition. While Dr. Pulley did question the alleged link between RSD or CRPS and Claimant's vascular symptoms, he deferred to the cardiologist who opined that such a relationship exists in this instance. Absent a contrary analysis by a qualified cardiologist, Claimant is entitled to care and treatment for his angina symptoms.

Other Medical Benefits

Other items of lifestyle-type relief Claimant demands are not supported by the record. For the most part, his need for these types of items are dependent upon his subjective reports of the severity of his symptoms and the brain function problems he describes, and in these respects Knight is not credible. These items include, *inter alia*, a motorized wheelchair, increased attendant care, a jacuzzi hot tub spa, and a larger apartment to accommodate the motorized wheelchair and spa. Accordingly, medical prescriptions for these types of items from physicians who have relied on his subjective complaints are not controlling. Claimant has not otherwise sustained his burden of establishing the medical necessity of such items.

Management of Medical Care

Employer's Request for
Medical Care Supervision

As previously mentioned, Employer also seeks relief in this matter in the form of an authorization which permits it to manage Claimant's care and medical treatment, to change his physicians, and initiate a multi-disciplinary program utilizing a pain management team of experts including internists, neurosurgeons, orthopedics, anesthesiologists, dermatologists, psychologists, physical and occupational therapists, and pharmacologists. Employer contends that Knight needs

medical treatment he currently rejects, and it denies that he requires the lifestyle relief he currently desires.

Employer cites to evidence of Knight's deteriorating medical condition over the past five years despite hundreds of visits to his present treating physicians, and emphasizes the testimony of Dr. Barsa that Knight's drug use is way up while his activity level is way down. In the Employer's view, Knight's "current physicians have utterly failed to help him." While Claimant vigorously objects to any change in his current treatment regime, the employer's observations are not entirely devoid of merit.

Notwithstanding the unrelenting agony Claimant describes despite years of treatment, he testified that his treatments with Dr. Hooshmand provide relief for periods up to several weeks or months if the claims adjuster does not cause him stress, and treatments administered by Drs. Green and Fralicker afford relief for several days or weeks. The record shows that Knight used crutches for about seven years and only occasionally used a wheelchair. Tr. 382. Yet, with medications totaling nearly $9,000 per month, (CX. FFF), and hundreds of visits to Drs. Green, Fralicker, and Hooshmand, his subjective symptoms have not subsided over the years, and he claims he is now wheelchair bound. Tr. 377-78; Tr. 383. Although he harbors no hope for any improvement, Knight fights to continue to utilize the treatment plans which have produced little benefit in arresting the pain and deterioration which brought him to his present condition. For the reasons which follow, however, I find it in Claimant's best interest that he be placed under the care of, according to his own treating physician, the nation's leading experts in the field of CRPS at the Cleveland Clinic.

Current Treatment Pattern and Prognosis

The record shows that in the year 2001, Knight visited Drs. Hooshmand and Hashmi in March, May, July, September, and October. Initially, he stayed in Vero Beach and received treatment from March 19-23. About a week later, on April 2, he visited Dr. Fralicker with pain symptoms, and returned to her on April 4, and 6, when he also saw Dr. Green, and returned to Dr. Fralicker on April 16 and 25, with an intermediate visit to Dr. Green on April 18. In May, he visited Dr. Hooshmand for three days ending on the 25th. Within a week, he went back to Dr. Green

reporting pain symptoms at unreduced levels. Despite two more visits to Dr. Green in May and seven visits to Dr. Fralicker, followed in June and July with twelve more visits to Dr. Fralicker ending July 13th, Knight returned to Drs. Hooshmand and Hashmi on July 16-20, reporting pain symptoms at unreduced levels. Two days after returning from five days of treatment with Dr. Hooshmand, Claimant on July 23, 25, 27 and 30 went back to Dr. Fralicker for more pain treatment. Nor is this an isolated pattern. It repeats month after month, year after year, even as Claimant reports that his pain levels, day to day remain essentially unchanged.

More importantly, both Drs. Green and Hooshmand concede that neither can do much more for Knight beyond the treatment and medication each has offered thus far. Dr. Green, for example, reports: "there is little else we can do except keep giving him medication and hope for the best." CX. M. Dr. Hooshmand's prognosis is no brighter: "All we can hope for is two things. Number one, keeping it from getting worse; number two, with help of infusion pump, giving him medication," pain relief. CX. DDD at Tr. 48-49. At present, however, fulfillment of either of Dr. Hooshmand's hopes is unlikely.

Measured by Claimant's activity levels, the medical intervention he has thus far received has failed to "keep it from getting worse," and any hope Dr. Hooshmand may repose in a pump is unrealistic for two reasons. First, Knight refuses voluntarily to submit to the psychological evaluation that must precede an implant trial, and second, despite his counsel's insistence that the Employer withheld approval of the pump over his objections, Knight spent considerable time at the hearing building a record of his objections to the pump apparently in anticipation that the Employer might suggest that it would do him some good. *See*, Tr. 463-64, 467-69, 475-77; CX. JJJ. [21] Thus, the path Claimant pursues yields

[21] Dr. Green strongly opposed an infusion pump for Knight believing that Dr. Hooshmand would agree with him. Dr. Hooshmand, to the contrary however, opined that the pump is the "only hope he's got left.... That is my strong belief." CX. DDD at Tr. 113-114. He discussed the pump with Knight, and detected no "objection to it." CX. DDD at Tr. 117. Dr. Hooshmand testified; "I believe it is the sensible thing to do, to try the pump.... (Tr. 118), "If the pump does not agree with patient, it is reversible." Tr. 120. According to Dr. Hooshmand, "Actual implantation is not invasive at all," Tr. 122, and there is "no need for transfusion, so no problem with Jehovah's Witness beliefs." CX. DDD at Tr. 123. At the hearing, Knight was unpersuaded by Dr.Hooshmand's analysis and continued to oppose the pump as a treatment option. Despite his objections, however, his attorney argued that the pump was a treatment option denied by the employer: "MR. JOHNSON: 'And the ultimate solution might be, what they constantly brought up was the morphine pump. I can assure the judge that I've asked them to authorize the morphine pump. They've declined to authorize the morphine pump.'" At page 28 of his post-hearing brief,

little relief in short bursts and offers virtually no hope. With some justification, the employer believes that the current treatment regime has failed as Knight's drug use escalated and his activity levels, contrary to Dr. Hooshmand's expectations and urging, steadily declined.

In the context of statements by a treating physician that the current plan is to keep "giving him drugs and hope for the best," and considering Claimant's detailed descriptions of his pain and suffering, recognizing that it is, in part, exaggerated and embellished significantly, it is difficult, nevertheless, to avoid concluding that Claimant would benefit from a broader, more comprehensive approach to his condition. Several physicians have, for example, suggested alternative treatment options. Drs. Barsa and Eichberg believe Knight needs a hospital in-patient evaluation and drug detoxification program leading to a comprehensive pain management program. Others, including Dr. Hooshmand, a treating physician, have suggested that Knight be evaluated for an infusion pump implant; still others would consider spinal stimulation. Several, including Drs. Hardy, Wittmer, Rowe, Pulley, Koslowski, Vincenty, Eichberg, and Barsa believe that Claimant would benefit from a comprehensive, multi-disciplinary pain management program. Claimant, however, remains suspicious of the motives and incentives of several of these physicians and discounts their opinions as a consequence.

The record shows, and I have found, that Knight developed RSD or CRPS as a result of his injury, and it causes him pain and discomfort. The record further shows, however, that Knight's behavior toward those who would evaluate or treat his condition is effected by his suspicions about the motives and incentives of many of the professional who have interacted with him, including, *inter alia*, his prior attorney, Dr. Knibbs, Dr. Hardy, Dr. Vincenty, Rick Robinson, Drs. Eichberg and Barsa, and Genesis Pain Management. *See also* e.g. EX 29 (Claimant is "Hostile and suspicious of all persons involved with his case."). With respect to Genesis, for example, Knight explained that he declined to participate in its pain management program because it required him to suspend taking his pain medication, an assertion denied by Ms. Davis and Dr. Wittmer, but he testified perhaps more candidly: "...my understanding, my impression when I was there, that they weren't really interested in helping me with what my medical needs were. Their focus, and what

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Claimant reiterates that "An infusion pump has been recommended for Mr. Knight, but the employer has not authorized it yet."

they were being paid to do was get me off of workers' comp, and off of, you know, my employer's financial responsibility within one month, no matter what it took." Tr. 562. No evidence in this record supports Claimant's "impressions" about Genesis, but his suspicions about that facility and others has had an adverse affect on his relationships with many experts who have been involved in his care.

At the hearing, the Employer expressed its willingness to provide the comprehensive program a majority of the experts agree Knight needs, and that it would provide it "locally, regionally or nationally, if necessary." Claimant, however, is not inclined to agree with any change in his current treatment regime. Employer, therefore, seeks an order which would permit a change in physicians and require Knight to participate in a multi-disciplinary pain clinic evaluation and treatment program. It argues that the District Director, in the past, has taken the position that OWCP lacks the authority to compel Knight to submit to an FCE, and has thus created an administrative and supervisory vacuum. Under such circumstances, it believes that the court has the authority under Section 7 of the Act to supervise the Claimant's medical care if such change is desirable and necessary in the Employee's best interest.

Authority to Intervene

Although the authority of the District Director is broader than it might have the Employer believe, See, 20 CFR §702.406, et seq., it is clear that the trier-of-fact also derives sufficient authority under Section 7 to consider and rule on the merits of the type of administrative intervention the Employer seeks in this case. Thus, in Sanders v. Marine Terminals Corp., 31 BRBS 19 (1997), the Board held that an ALJ has authority under Section 7 and 19(d) of the Act and the APA to adjudicate "disputed factual issues such as the need for specific medical care or treatment for a work-related injury..." Sanders at 22; *See also*, 20 CFR §702.406, et seq.. As the Claimant observes, however, an ALJ is not well-positioned to undertake the day-to-day supervision of a Claimant's medical care, and I completely concur. Nevertheless, there are situations which present extraordinary circumstances warranting intervention, and this is just such a case.

Cleveland Clinic

Suspicions and recriminations aside, there is in this record a convergence confidence expressed at various times by both parties in one facility above all

others. For the care and treatment of RSD/CRPS, the resources of the Cleveland Clinic are unsurpassed. Legal and collateral non-medical strategies and considerations have, in the past, imposed obstacles to securing the needed expertise as the parties bobbed and weaved, jousting for position, both, at times, demanding, and, at times, objecting to a visit to the Cleveland Clinic, but through it all, neither party questioned the singular expertise available at that facility, and the time for sparring is now over.

The record shows that at various times Claimant and the Employer sought approval from the other for a voluntary visit with Dr. Stanton-Hicks. Claimant, in particular, made an especially poignant plea for an order compelling the employer to authorize such an evaluation. In his pleadings filed before Judge Teitler on October 21, 2001, Claimant argued:

> On July 7, 1998, Dr. Jacob Green, the Claimant's treating physician, referred the Claimant for evaluation with Stanton Hicks M.D., located at the Cleveland Clinic, Cleveland, Ohio. (Deposition Dr. Green 8/13/99, p.52, 53). Dr. Hicks is a professor and head of pain services at the Cleveland Clinic, and is an internationally known expert in RSD. (Deposition Dr. Green 8/13/99, p. 52, 53, 61, 62). Dr. Hicks has written extensively on the topic of RSD and is "one of the world's most renowned and prolific writers on RSD." (Deposition Dr. Green 8/13/99,p. 53, 61). Dr. Green wishes the Claimant to see Dr. Hicks given the rarity and the severity of the Claimant's condition, to determine whether Dr. Hicks can add treatment ideas to attempt to improve the Claimant's condition. (Deposition Dr. Green 8/13/99 p. 57, 49). "I think [the Claimant] should be given every chance because of the amount of pain and difficulty he has." (Deposition Dr. Green 8/13/99 p. 59). "If he was your kid or my kid, I'd think we'd want him to go see the world's
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> greatest expert and see if there's anything at all that they would come up with that hasn't been tried." (Deposition Dr. Green 8/13/99, p. 49)." Cl. Br. At p. 10 10/21/01.

Claimant's counsel now advises that he no longer wishes to seek Dr. Stanton-Hicks' help, but the circumstances described by Dr. Green are equally, if not more compelling today. Accordingly, based upon all of the forgoing factors considered in light of the evidence viewed in its totality, I find that a visit to the Cleveland Clinic not only for an evaluation, but for care and treatment of his condition is in Claimant's best medical interest. Accordingly, the Employer will be ordered to authorize and Claimant will be compelled to appear at the Cleveland Clinic, unless the parties by mutual agreement choose another facility, where he shall undergo evaluation and treatment, including detoxification, if deemed necessary by experts at the Clinic. Further, to insure a seamless transition to the care of the Cleveland Clinic, the Employer will be ordered, until such time as an alternative care and treatment regime, if any, is formulated by the staff of the Cleveland Clinic, not to reduce the care, treatment, home aid, medications, or other benefits Claimant currently receives in accordance with authorizations previously approved by the Employer. Claimant may decline to participate in a particular type of evaluation or treatment modality which conflicts with the religious beliefs of the Jehovah's Witnesses, and may also decline to undergo any surgical or implant procedure pending further adjudication of the reasonableness of such refusal based upon the facts and circumstances at the time any such medical procedure may be recommended, but in all other respects, Claimant's full cooperation will be required.

Psychological Evaluation

Now, one aspect of the pain clinic model which is likely to cause some difficulty, as this record demonstrates rather clearly, is the consideration of the factors which may involve the services of a psychologist. Drs. Hardy, Koslowski, Tandron, Rowe, Pulley, Eichberg, and Barsa all believed that Knight would benefit from a pain management team approach including a psychological component, and Dr. Hooshmand indicated that he would have no objection to an evaluation of any potential psychological aspects of Claimant's condition. Yet, Knight remains adamantly resistant to the notion that there may be a psychiatric or psychological component to his present condition, and except to the extent discussed below, his objections are unreasonable.

Thus, Knight was asked at the hearing whether he would willingly undergo psychological evaluation and treatment. He testified;

> "No, because I grew up, my uncle is a psychologist and I'm well experienced. I studied psychology all through

> school and I'm quite familiar with it and I have, you know, an understanding of what it's based on. And a lot of it is not based on science. It's not based on fact. That's why a psychologist can not prescribe medicine. Only a psychiatrist can. And it's like some of the things that Dr. Willmer or Wittmer said I totally disagree with. His attitude was that if I came from a, I'll use the term dysfunctional family, then I'm potentially going to be a dysfunctional person the rest of my life, no matter what, no matter what I want to be. That's like saying that once somebody, you know, shows any personal character flaw at all, it can never change, that they can never be a better person, even if they desire to. Well, that's just silly.
>
> And my bible based education tells me that there's much more value in other types of therapy. And no doctor has recommended that for me." Tr. 559-560.

Although several doctors have recommended a team approach to his problem, including the involvement of a psychologist, Knight, based upon his high school study of psychology, seemed inclined to self-diagnose his condition and report: "I don't see any need for that because there's no problems that are based in that area, you know...." Tr. 559-560; *See also*, Tr. 568-69. Other experts are not so sure.

I am mindful that Knight also suggested that, as a Jehovah's Witness, he had religious beliefs which conflicted with certain aspects of psychological or psychiatric treatment and stated that OWCP advised him that if his "beliefs disagree with that, you don't have to submit to the treatment..." Knight explained that some forms of psychiatric and psychological care "violate his religious beliefs."[22]

As previously recognized, however, to the extent that a particular aspect of mental health evaluation, counseling, or treatment is inconsistent with the religious convictions of the Jehovah's Witnesses, Knight reasonably may refuse to cooperate

[22] According to articles published in the Watchtower, as reported on the Jehovah's Witnesses Official website, www.watchtower.org, faith healing is to be avoided and blood transfusions are impermissible, but there appears to be no general admonition against psychological or psychiatric counseling for those in need of such treatment.

or participate in that specific aspect of the examination or treatment modality. Any such refusal, however, must be grounded, in good faith, upon the tenets of the Jehovah's Witnesses. Beyond that, Knight's general objections to the involvement of a psychologist or other mental health professional in his evaluation, care, or treatment, based upon his high school studies or his personal misunderstandings about the science and theories of psychology or his belief that "there are no problems in this area," are not reasonable and do not justify a refusal to cooperate.[23]

Travel Arrangements

Based upon the pre-trial adjudication of issues relating to travel needs and Claimant's suspicions regarding those who would transport and examine him, an order will enter which requires the Employer, in consultation with Claimant, to make and pay for all his medical needs in preparation for and arrangements involving Claimant's travel by ground and/or air transport at Claimant's discretion, and for his stay at the Cleveland Clinic. Such modes of travel shall include transportation to and from his home to the airport or ground transportation terminal, assistance at the departure and arrival terminals, and transportation to and from the Clinic. Air transportation may include, if Claimant wishes, non-stop air service from Orlando to Cleveland.[24] Should Claimant elect to make his own travel arrangements, he will be permitted to do so at his own expense. Employer will

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[23] The record shows, for example, that Knight was reluctant to, and in fact did not, meet with Rick Robinson, the vocational expert, in part because he thought that Robinson was a mental health counselor. Knight testified: "... the letter he sent to me had one, I think one set of initials next to his name, you know, like a credential abbreviation, but the letters he sent to my doctors that he referenced today, he sent them some questionnaires, he had like six abbreviations of credentials, including one that said, I think it's LMHC, which is supposed to stand for licensed mental health counselor and that was a concern because I didn't really agree with that type of counsel and I wasn't sure if that's what I was being sent there for because they had misrepresented to me a couple of times...."

[24] I have concluded that a visit to the Cleveland Clinic is not only in Claimant's best interest but is, in light of the expertise which it can singularly provide, reasonably convenient. In reaching this conclusion, I have taken into account Claimant's ability to make such a trip. Thus, Dr. Green, Knight's treating physician, first proposed that Claimant see Dr. Stanton-Hicks, and Claimant sought an order compelling Employer to authorize such travel in his October 21, 2001 pleadings before Judge Teitler. Further, Claimant travels frequently by ground transport to Vero Beach and airports in his vicinity are closer to his home than that. And once aboard the aircraft, Claimant, as demonstrated at the hearing, retains the capacity to sit fairly comfortably during the two and one half hour non-stop flight from, for example, Orlando to Cleveland.

remain responsible in that event for all costs associated with the care and treatment provided by the Clinic.

Authorizations and Other Arrangements
at the Cleveland Clinic or
Other Mutually Agreed Upon Facility

In addition, Claimant will be ordered to execute all authorizations required by the Clinic for patients ordinarily admitted to that facility, but he will not be required to authorize any care or treatment which conflicts with the religious beliefs of the Jehovah's Witnesses. For purposes of this visit, Claimant will not be authorized to tape record, either audio or video, any aspect of his evaluation, care, or treatment at the Clinic unless such recording is consistent with Clinic policies applicable to other patients. Further, if Claimant wishes to travel with a companion, he may do so at his own expense; however, a visitor or companion may accompany Claimant to any evaluation, examination, or treatment session at the Clinic only to the extent that the presence of a third party is consistent with Clinic policy applicable under similar circumstances to other patients.

Finally, upon his discharge from the Clinic and return home, the Employer will be required to provide Claimant with all medical care and treatment, medications, and other necessities, including home attendant care, if any, that the Cleveland Clinic may prescribe. Claimant, as noted above, will be placed under no obligation to submit to a recommended treatment which conflicts with the beliefs of the Jehovah's Witnesses or agree to any implant procedure pending further consideration of the reasonableness of his rejection at the time such recommendations may be made. Accordingly:

ORDER

I. IT IS ORDERED that Employer pay to Casper Knight compensation for temporary total disability commencing May 8, 1995, to date and continuing based upon an average weekly wage $520.00, with interest for the September 20, 2001 to January 4, 2002; provided, however, that Employer shall be given credit for compensation previously paid; and

2. IT IS FURTHER ORDERED that Employer shall reimburse Claimant for his out-of-pocket medical expenses incurred during the period benefits were

suspended from September 20, 2001 to January 4, 2002; and shall be reimburse him for one half (½) of his documented out-of-pocket expenses incurred for the visit to Drs. Eichberg and Barsa in Tampa; provided, however, that Employer shall be given credit for such expenses which it has previously paid; and

3. IT IS FURTHER ORDERED that Employer, henceforth, and whenever it submits a payment to Claimant, shall provide him with a list which identifies the purpose and the amount of each item covered by the payment and/or the period covered by each compensation payment; and

4. IT IS FURTHER ORDERED that Employer provide the following medical benefits; wheelchair pillow; a flu shot; transportation to and from Neurological Associates and Southeastern Neuroscience; hand and shoulder treatments related to the use of crutches; and treatment and medication of vasospasms and skin rash; and

5. IT IS FURTHER ORDERED that Claimant's request for additional lifestyle relief such as 32 hours per week of home aid, a motorized wheel chair, a Jacuzzi hot tub, and new living quarters be, and hereby are, denied; and

6. IT IS FURTHER ORDERED that the Employer shall, within 45 days of the date of this order and in consultation with Claimant, schedule him for evaluation, care, and treatment by or under the supervision of Dr. Michael Stanton-Hicks at the Cleveland Clinic, Cleveland, Ohio, unless the parties by mutual agreement choose a different facility; and provided further that Employer, at its expense, shall provide such medical care and treatment as may be necessary to prepare Claimant for travel and shall provide all ground transportation, air transportation, and/or both, including as Claimant may choose, non-stop air service from Orlando, Florida to Cleveland and return; and

7. IT IS FURTHER ORDERED that Claimant may elect to make his own travel arrangements at his own expense unless such arrangements are made by mutual agreement, in writing, whereupon such arrangements made by mutual agreement shall be paid for by the Employer; and

8. IT IS FURTHER ORDERED that the Employer shall not reduce the care, treatment, medications, home aid, or other benefits Claimant received at the time of the hearing or as set forth in Paragraph 4 of this order, until such time as Claimant is admitted at the Cleveland Clinic, after which, all medical benefits previously

provided shall be suspended and replaced, at Employer's expense, by the medical evaluation, care, and treatment, including but not limited to medications provided or prescribed by the Cleveland Clinic during his admission, and as the Cleveland Clinic, or other medical provider acting upon the Clinic's recommendations, may thereafter prescribe, including but not limited to medications, treatments, transportation, and home attendant care, if any, upon Claimant's return home; and

9. IT IS FURTHER ORDERED that Claimant shall execute all authorizations required by the Cleveland Clinic for patients ordinarily admitted to the facility or as may be required to carry out the purposes of his admission, and Claimant shall appear at the facility, as scheduled, where he shall undergo such evaluation, care, and treatment as the staff of the Cleveland Clinic, under the supervision of or in consultation with Dr. Stanton-Hicks, may prescribe, including psychological or psychiatric evaluation, care, or treatment; provided, however, that Claimant shall not be required to submit to any evaluation, care or treatment, which is contrary to the tenets of the Jehovah's Witnesses, and provided further that nothing in this order shall be construed as requiring Claimant to submit to any implant procedure pending appropriate review of the reasonableness of any objections he have to such a procedure; and

10. IT IS FURTHER ORDERED that notwithstanding the provisions of Paragraphs 6, 7, 8, and 9 above the parties may, by mutual agreement, select a facility different from the Cleveland Clinic, and, in such circumstances, the provisions of Paragraphs 6, 7, 8, and 9, above will apply to Claimant's visit to that facility; and

11. IT IS FURTHER ORDERED that Claimant shall not tape record, either audio or video, any aspect of his evaluation, care, or treatment at the Cleveland Clinic, or other facility selected by mutual agreement, unless such recording is consistent with the facility's policies applicable to other patients; and provided further that Claimant may be accompanied by or visited by a companion at his own expense; however, any such companion or visitor may not accompany Claimant to any evaluation, examination, or treatment session unless the presence of a third party is consistent with the policy of the Cleveland Clinic, or other facility, applicable under similar circumstances to other patients.

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Stuart A. Levin
Administrative Law Judge
Signed: March 11, 2003